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***Reproductive Health  
Communication in Kenya:  
Results of a National  
Information, Communication,  
and Education Situation Survey***

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## Abbreviations

CBD	community-based distribution
CBS	Central Bureau of Statistics
CNN	Cable News Network
CSA	Center for the Study of Adolescence
FGM	female genital mutilation
FLE	family life education
FPAK	Family Planning Association of Kenya
GNP	gross national product
HIV/AIDS	human immunodeficiency virus/acquired immune deficiency syndrome
ICS	Innovative Communication Services
IEC	information, education, and communication
ISSA	Integrated System for Survey Analysis
IUD	intrauterine device
JHU/CCP	Johns Hopkins Center for Communication Programs
JHU/PCS	Johns Hopkins University/Population Communication Services
KCPS	Kenya Contraceptive Prevalence Survey
KBC	Kenya Broadcasting Corporation
KDHS	Kenya Demographic and Health Survey
KFS	Kenya Fertility Survey
KNIECSS	Kenya National Information, Education, and Communication Situation Survey
KTN	Kenya Television Network
NASSEP III	National Sample Survey Evaluation Programme
NCPD	National Council on Population and Development
NFP	Natural Family Planning
NGO	nongovernmental organization
PRB	Population Reference Bureau
STD	sexually transmitted disease



## Summary

Between August and September 1994, the National Council for Population and Development (NCPD) and the Johns Hopkins University Population Communication Services (JHU/PCS) implemented the Kenya National Information, Education, and Communication Situation Survey (KNIECSS). This study is intended to be used as a baseline for new IEC initiatives, an impact evaluation for ongoing activities, and as a measurement of media patterns to supplement to the 1993 Kenya Demographic and Health Survey (KDHS). The survey was conducted in 35 districts and covered 269 census clusters. It was designed to mirror the 1993 KDHS. Therefore, participating clusters were selected randomly from those used in the 1993 KDHS. Analysis reveals that KNIECSS is closely comparable to the KDHS.

A total of 6,320 adults and adolescents were interviewed in the KNIECSS, including 997 adolescents ages 10 to 14 and 953 of their parents, 1,476 adolescents ages 15 to 19, and 2,894 adults ages 20 and older. Half the respondents were male, just under 20 percent resided in urban areas, over 90 percent were Christian, and about 75 percent of adults were married. Roughly 90 percent of adult women had children, each had an average of two boys and two girls. Data reveal high levels of education in Kenya—virtually all adolescents (over 95 percent) had attended school compared with 85 percent of adults. Among working adults, the main occupation for both men and women was farming.

Many Kenyans were involved in social clubs—anywhere from one-third to just under one-half of respondents belonged to some type of social association. Women were more likely to belong to such a group than men, and religious clubs and women's groups were the most common affiliations cited by respondents.

**Media habits.** Appreciable proportions of respondents said they read the newspaper, with adult males (73 percent) as the most likely to read one. In contrast, only 34 percent of adult women reported reading newspapers. Most readers read a newspaper only one to three days a week, and again adult men (23 percent) were most likely to read one daily. Over 70 percent of readers read *The Nation*, making it the most popular paper in Kenya.

Anywhere from two-thirds to three-fourths of respondents resided in households that had a radio, and one- to two-thirds of the sample listened to the radio every day. The most popular listening times for listeners in all groups was in the evening from 6:00 p.m. onwards. The majority of radio listeners (over 75 percent) listened to the Swahili station Kenya Broadcasting Corporation National Service (KBC). News was the most popular program across all age groups. Most listeners (80 percent or more) listened to the radio at home; the remainder, especially males, listened at a neighbor's or friend's house, school, shops, markets, or other commercial outlets.

Just under 14 percent of respondents resided in households that had a television set. Regardless of whether they lived in a household that had one or not, 30 percent of the sample said they watched television. Television viewership was less frequent than radio listenership, and less than 11 percent watched daily. Among those who watched, over 90 percent watched KBC, and less than 25 percent watched the Kenya Television Network (KTN). The majority of those who watched television did so between 7:00 p.m. and 9:00 p.m.

**Exposure to family planning information in the mass media** When asked where they heard about family planning, most adult males and adolescent males and females said radio, while adult women cited health workers. Schools were also an important source of information on family planning among adolescents. When asked directly if they had heard family planning information in the mass media in the six months preceding the survey, the majority (over 60 percent of adolescents and over 75 percent of adults) said that they had. Adult males were more likely to report exposure to family planning messages, regardless of the medium.

Roughly 76 percent of adult men and 68 percent of adult women said they had heard the JHU/PCS-supported family planning radio drama, *Kulewana ni Kuzungumza*. Over 60 percent of adolescent males and females reported hearing the program as well. Nearly 34 percent of adult males also had seen the JHU/PCS-sponsored vasectomy advertisements in newspapers. Among men who read newspapers, 45 percent had been exposed to those advertisements.

**Family planning awareness, use and source** Over 90 percent of respondents ages 15 and above were aware of the term “family planning” or its vernacular translations. Detailed knowledge of family planning, however, appears less widespread. For example, many believed that males can take the birth control pill or that two pills taken just before sex can prevent pregnancy. Nevertheless, aside from concerns about side effects, most respondents held favorable attitudes toward family planning.

Just over 66 percent of adolescents could spontaneously name a method of family planning compared with nearly 90 percent of adults. The most commonly known modern methods were pills and condoms. Some methods remained unfamiliar even after assistance—over one-third of respondents said they had not heard of vasectomy, foaming tablets, Norplant<sup>®</sup>, or diaphragm. Adolescent males knew 5.0 methods compared with 5.4 for adolescent females, and adult males knew 8.0 methods compared with 7.6 for adult females (assisted and spontaneous awareness combined).

One-fourth of adolescent males ages 15 to 19, and about the same proportion of their female counterparts, had ever used contraception, and around 15 percent of each gender was using a method at the time of the survey. Among adults ages 20 and older, 64 percent of men and 58 percent of women had ever used a method, and 42 percent of men compared with 36 percent of women were using one at the time of the survey. Approximately 27 percent of adult females currently using were using a modern method, and 5 percent were using a nonmodern method. There were differences in obtaining methods—adolescent males were most likely to obtain methods from shops, kiosks, or similar outlets, while all of the other groups surveyed were most likely to get methods from a health facility.

The main reason given by sexually active adolescent males and females for not using contraception was that the respondent was not married. Thus, adolescents, even if they are sexually active, appear to see contraception largely within the context of marriage. Among adults, the main reasons cited by nonusers were fertility-related, either they wanted more children or recently had a child and were breastfeeding. The majority of nonusers, however, intended to use “in the near future.”

Roughly one-third of adult respondents were aware of the existence of community-based

distribution (CBD) agents and had a general idea of what they did. Data also found that CBD agents are referred to by many other names, such as family planning worker, health worker, or “city commission,” depending on where the respondent lived and what CBD organization operated there. Nearly 33 percent of women of reproductive age (ages 15 to 49) had seen a CBD working in their neighborhood, and 18 percent had received a visit from one.

**Communication between spouses, parents, and children** Married couples were asked how often they had discussed family planning with their spouses in the year preceding the survey, and 27 percent of men and 33 percent of women said they had not spoken at all. Of the several topics listed (finances, future plans, children's education, religion, and family planning), couples were least likely to have discussed family planning. On a positive note, data also show that some males *do* initiate discussions about family planning—among respondents who had discussed the subject, 44 percent of males, compared with 57 percent of females, said they usually initiated the discussion. For the most part, these conversations were supportive of family planning. Nearly one-third of those who had not talked to their spouse about family planning said they wanted to, and roughly one-half also said they intended to speak to him/her.

The majority of adolescents did not communicate often with parents about reproductive matters. Less than half the parents had talked to their teenage children about boy/girl relationships, human immunodeficiency virus/acquired immunodeficiency syndrome (HIV/AIDS) and other sexually transmitted diseases (STDs), pregnancy prevention, or similar reproductive health topics in the year preceding the survey. Data also revealed gender-specific communication patterns—fathers were more likely to have talked to their adolescent children about school-oriented topics such as academics and future career, while mothers were more likely to have talked to the children about reproductive health issues. Adolescents appear uneasy talking to their parents about sexual matters—out of 11 individuals listed in the questionnaire, adolescents said they were most uncomfortable talking to fathers (for girls) and mothers (for boys), but were most comfortable talking to friends, brothers (for males), sisters (for females), and health care workers.

**HIV/AIDS.** Virtually all (over 97 percent) respondents ages 15 and above reported they had heard of HIV/AIDS, but specific knowledge remained low among adults and adolescents alike. For example, nearly one-third of young people and adults believed one could contract HIV/AIDS through insect bites, about one-fourth believed one could contract it through secondhand clothes, and a similar proportion thought one could acquire the disease by sharing cups, plates, and forks with others.

There also appears to be a general mistrust of condoms—almost 30 percent of adult and adolescent males and nearly 40 percent of adult and adolescent females did not believe condoms could protect against HIV/AIDS. The main reasons for the skepticism were the belief that condoms could burst and/or have holes. The majority of adult and adolescent respondents got their information about HIV/AIDS from the radio. The second most important source was friends, followed by school for adolescents, print materials for adult males, and health care providers for adult women.

In Kenya, there appears to be a mixed reaction to persons infected with AIDS—as high as one-third of the sample said they would not speak to a relative with HIV/AIDS in public. A similar

proportion said they would not visit his/her room and another one-third would not shake his/her hand. Almost half would not use plates used by an individual with HIV/AIDS, would not wear his/her clothes, and would not let his/her (respondent's) children play with him/her. About two-thirds said they would take care of the relative when he/she was ill, however.

**Adolescent reproductive health** Both adolescents and adults appear to hold views indicative of an expectation that most adolescents will experience premarital sexual activity. When asked what the ideal age at first intercourse and marriage for young people should be, both groups gave ages at first sex which were at least three years younger than ages at marriage. However, when asked directly whether sex before marriage is acceptable, less than one-third agreed.

Respondents expressed displeasure at schoolgirl pregnancy and favored expelling pregnant students. Over 54 percent said girls who become pregnant while in school should be expelled. When asked whether schoolboys who made schoolgirls pregnant should also be expelled, just over half said they should. Respondents, especially female respondents, were more punitive toward pregnant girls and gave a stronger endorsement for their expulsion than for the expulsion of boys.

Most respondents were strongly opposed to abortion, even in the cases of endangerment to the mother's life, fetal deformity, rape, or incest. Females opposed abortion more than males. Nearly 40 percent of respondents also knew someone who had had an abortion, and 50 percent of these knew two or more such persons.

Over three-fourths of adolescents and adults felt that young people should be taught family life education in school. Regarding specific topics, 70 percent (or more) of adolescents and adults felt that young people should be taught about STDs including HIV/AIDS, family planning, how a woman becomes pregnant, puberty, and alcohol and drug use. Similar support was found when data for parents of adolescents ages 10 to 14 years were examined.

More than 70 percent of adolescents ages 15 to 19 had entered puberty (began menstruation or experienced wet dreams). However, 40 percent to 50 percent did not know what was happening to them when this occurred for the first time. Many girls thought they were sick or had hurt themselves, while many boys thought they were sick or were bed-wetting.

Roughly 66 percent of unmarried males ages 15 to 19 and 40 percent of their female counterparts stated they were sexually active (ever had intercourse). The mean age at first sex for sexually active males was 14 years and for sexually active females it was 15 years. Roughly 83 percent of males and 50 percent of females said they had had more than one partner since their first sexual experience. The mean number of sex partners for males was four, the mean for females was two. The main reason males had engaged in sex the first time was "to enjoy myself" while females said it was "to show love." Nearly 15 percent of females said their first sexual encounter was "forced." While the research did not investigate what "forced" meant, it implies that many young girls may not have had intercourse willingly.

## Chapter I. Introduction

### Demographic, Cultural, and Economic Profile

Kenya is situated on the eastern coast of Africa and bisected by the equator. The country covers a total area of 582,646 square kilometers, including the narrow coastal plain, the semi-arid region of the West and North, the highlands including the great Rift Valley, and the plateau surrounding Lake Victoria. Almost two-thirds of the country is arid or semi-arid, consequently about 75 percent of Kenya's population is confined to only 10 percent of the land mass (Morgan, 1993).

Administratively, Kenya is divided into eight provinces, each headed by a Provincial Commissioner. Each province is divided into several districts, each headed by a District Commissioner. The country is presently undergoing significant political and organizational changes, with new districts being carved out of existing ones. At the writing of this report, there were roughly 45 districts; news reports suggest additional districts are under consideration.

Kenya's population has rapidly increased, rising from 5.4 million in 1948 (Republic of Kenya, 1989) to a current UN (1996) estimate of 29 million in mid 1994. [see Table 1.1] The major determinants of this increase have been substantial declines in mortality, particularly infant and child mortality, and an increase in fertility. The total fertility rate was as high as 8.1 in 1975-77, but had declined to 5.4 in 1993 (NCPD, 1996). The crude death rate declined from 25 per 1,000 population in 1948 (Republic of Kenya, 1989) to a current estimate of 12 per 1,000 population 1993 (UN, 1996). The infant mortality rate dropped by nearly two thirds, from 184 per 1,000 live births in 1948 to 69 per 1,000 live births in 1993. At the same time, life expectancy of Kenyans improved from 44 years in 1962 (Republic of Kenya, 1989) to 59 years in 1993 (UN, 1996)—one of the highest life expectancy rates in sub-Saharan Africa. At its peak, the population was growing at an annual rate of 4.2 percent in 1988 (PRB, 1988) one of the highest ever recorded. However, evidence suggests that growth has slowed and is now about 2.7 percent per year (PRB, 1996). This decline has been linked to the increase in the contraceptive prevalence rate from 7 percent in 1978 to 17 percent in 1984, 27 percent in 1989, and 33 percent in 1993 (NCPD, 1994). Kenya is a land of cultural diversity; the population can be divided into people of Bantu, Nilotic, Nilo-Hamitic, and Cushitic groups. Persian and Arabic influence on the coast is also seen in the Islamic culture. There are about 43 main ethnic groups, which all have different cultural practices, languages, and familial relationships. The main religions are Christianity and Islam. The national language is Kiswahili, and the official language is English (NCPD, 1994). Agriculture is the main occupation and source of income for the majority of people in Kenya.

**Table 1.1**  
**Trends in Demographic Indicators. Kenya. 1948-1994**

	1948	1962	1969	1979	1989	1994
Demographic Indicator	Census	Census	Census	Census	Census <sup>a</sup>	Projections
Population (millions)	5.4	8.6	10.9	15.3	21.4	29.0
Annual population growth rate (%)	2.5	3.0	3.3	3.8	3.4	3.2
Crude birth rate	50.0	50.0	50.0	52.0	47.0	42.0
Total fertility rate	6.0	6.8	7.6	7.9	6.7	5.4 <sup>b</sup>
Crude death rate	25.0	20.0	17.0	14.0	13.0	10.0
Infant mortality rate	184.0	n/a	118.0	104.0	80.0	75.0
Life expectancy (years)	35.0	44.0	49.0	54.0	58.0	59.0

SOURCE: Republic of Kenya, (p. 207); UN, 1996, PRB, 1994. Government of Kenya, Population Census Reports; NCPD, 1994.

NOTES: <sup>a</sup> Provisional figures.

<sup>b</sup> Estimate from the 1993 Kenya Demographic and Health Survey.



In the period following independence, the economy grew rapidly, making Kenya one of the most successful countries in Africa. The 1980's, however, ushered in a period of economic deceleration, brought about by the world economic recession, high population growth rate, poor performance of the agriculture sector, Structural Adjustment Programmes, and inadequate gross investment. These factors and others have compounded the poverty problem, adversely affecting various vulnerable groups such as children, adolescents, women, urban poor, landless people, pastoralists, and the unemployed. The gross national product (GNP) per capita is currently \$360, rating Kenya as a low income country (World Bank, 1992), a significant decline from the figures in the 1970's.

## **Challenges Facing Young People**

The definition of young people in Kenya is broad, and the age criteria that brackets this period varies according to life situations such as marriage, voting, military service, employment, etc. If defined as individuals between the ages of 10 and 19 (WHO, 1995), young people comprise 25 percent of Kenya's population, based on the 1989 Census (CBS, 1994). Because they are neither adults nor children, they have traditionally been overlooked in policy and programmatic priorities.

Such an exclusion can have direct consequences on their well-being, particularly in the areas of health, education, and access to gainful employment. One of the most critical areas is reproductive health. In the recent past, the government has acknowledged the importance of educating young people on reproductive health matters and providing them with reproductive health care (see the government's Sessional Paper No. 4, 1984, on Population Policy Guidelines). Spearheaded by the National Council for Population and Development (NCPD) it has embarked on several initiatives aimed at addressing adolescent reproductive health. These efforts are timely. The National AIDS Control Program estimates that if current human immunodeficiency virus/acquired immune deficiency syndrome (HIV/AIDS) trends continue, over half a million young people between the ages of 15 and 24 will be infected by the year 2005 (Ministry of Health [MOH] National AIDS Control Program [NCPD], 1992). Moreover, many adults with HIV/AIDS today may have acquired the infection during their teenage years. Sexual activity, often unprotected, is thought to be common among young Kenyans. Data from the 1993 KDHS show that 46 percent of unmarried women between 15 and 19 years of age are sexually active, and that sexual activity usually precedes marriage among both men and women (NCPD, 1994). The KDHS does not collect comparable data for men ages 15 - 19 but analysis among these suggests that adolescent males are more sexually active than females the same age.

An analysis by the Center for the Study of Adolescence (CSA) suggests that roughly 252,800 abortions occur annually among adolescents ages 15 to 19—a rate of nearly 700 abortions a day (Njau and Radney, 1995). Abortion is documented to be one of the most common reasons for admission in Kenyan hospitals (Lema and Kabebere Macharia, 1992). Estimates indicate that nearly 10,000 girls who become pregnant are expelled from school annually—about 30 girls a day—while the males involved are largely not penalized (Ferguson, 1988). Although the Minister of Education has recently called for re-admission of the girls after delivery, implementation is far from widespread, and many parents and teachers are not supportive. Girls who return to school after delivery are often derided and ridiculed, and many eventually drop out or transfer to another institution.

There is very little information on the media habits and the communication patterns of youth in Kenya, yet media is a central element in educating young people. KНИЕCSS provided an opportunity to gather these data.

## **Mass Media in Kenya**

Kenya's only nationwide radio station is the government owned Kenya Broadcasting Corporation (KBC). Recently, two new private stations, Capital FM and Metro FM, have begun transmission, but these only

reach the Nairobi area. KBC has two national channels, the General Service, which broadcasts in English, and the National Service, which broadcasts in Kiswahili. It has also launched a new FM station but this only broadcasts in Nairobi. KBC also has an array of other smaller channels that broadcast in vernacular languages at various times of the day. Listeners with shortwave radios can also receive international transmissions including the BBC World Service, Deutsche Welle radio, Channel Africa, Radio Uganda, Voice of America, Radio France International, and numerous other stations.

There are two television stations, the Kenya Broadcasting Corporation (KBC) and the Kenya Television Network (KTN). KBC is the oldest television station in Kenya, and is the main broadcaster of national and international news and local programming. Recently, KBC has branched out with another channel, KBC Channel II, which specializes in sports, movies, and foreign news. KBC broadcasts nationally, while KTN is limited to the Nairobi area. Recent news reports suggest that several more television stations may soon begin broadcasting in Kenya.

Kenya has three main English-language newspapers: *The Nation*, *The Standard*, and *The Kenya Times*. *The Nation* is by far the most widely read. A regional newspaper, *The East African*, has been recently launched. There are other smaller English-language newspapers such as *People*, which circulate predominantly in larger towns. The main vernacular language newspaper is *Taifa Leo*, a Swahili-language paper and sister publication of *The Nation*. *Taifa Leo* is widely read. International newspapers such as the *Herald Tribune*, *Financial Times*, and *Le Figaro* also are available in larger towns.

The country has a large number of local magazines covering various topics such as news, finance, fashion, family issues, and entertainment. News and current affairs magazines include the *Weekly Review*, *Society*, *Finance*, and *The Economic Review*, among others. Magazines such as *Parents*, *Lady*, *Step*, *Drum*, *Nairobi Monthly*, *Development Horizons*, and *Psychology Today* focus on issues such as business and development, industry, family matters, and health. In addition, Kenya receives a large supply of international magazines such as *Time*, *Newsweek*, *The Economist*, *Match*, *Vogue*, and *Reader's Digest*.

### **Information, Education, and Communication Initiatives in Kenya**

The use of mass media, including radio, television, and print, for educational programming is common in Kenya. The Ministry of Education has been broadcasting lectures to primary and secondary schools using interactive radio for the past several decades. Public education programs such as *Akina Mama* (For Women), *Daktari Wa Radio* (Radio Doctor), *Maisha Bora* (Quality Life), and *Kwenu Wakulima* (To You Farmers) are common on radio. Health education interventions have long recognized the value of radio and print media and rely on them heavily. While it is not as accessible as radio, television is also used to disseminate health messages.

The Johns Hopkins Center for Communication Programs (JHU/CCP) has been active in Kenya since 1984, collaborating with governmental organizations such as the National Council for Population and Development (NCPD), the Ministry of Health, and the Ministry of Information. In addition, JHU/CCP has worked with nongovernmental institutions such as the Family Planning Association of Kenya (FPAK), Innovative Communication Services (ICS), the Center for the Study of Adolescence (CSA), and various mass-media institutions. JHU/CCP has assisted with a wide array of information, education, and communication (IEC) activities designed to improve reproductive health care services and to assist couples in making informed decisions about their fertility. JHU/CCP has supported the development of several radio and television programs, promotional jingles and spots and has dubbed and distributed full-feature health films for public viewing. It has also assisted in the development and distribution of print materials for family planning providers and their clients. It has been involved in the training of community-based distributors and clinic-based family planning providers in both the private and public sectors. It has assisted in the development and implementation of interventions targeted at men and adolescents, groups

that are often overlooked.

All JHU/CCP projects include extensive formative research to guide the development of materials and to serve as a basis for program evaluation. Because JHU/CCP has had several projects in Kenya over the past few years, a survey that would provide a snapshot of the status of these activities was desirable in Kenya. This survey would provide information for ongoing projects and baseline data for future projects. For these reasons the Kenya National IEC Situation Survey was implemented.

## Chapter II. Methods

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### Survey Objectives

The major objective of the Kenya National IEC Situation Survey (KNIECSS) was to provide information on a variety of factors that influence reproductive health, to provide data regarding the impact of ongoing IEC activities, and to yield insights into existing gaps that may require attention. The survey was conducted among adults and adolescents to collect the following information:

- Media habits;
- Exposure to family planning IEC activities;
- Attitudes toward and understanding of family planning and child spacing;
- Patterns of communication about family planning;
- Family planning decision-making patterns;
- Family planning use, reasons for nonuse, and intentions for future use of contraceptives;
- Factors that influence use of family planning methods;
- Perception of service providers, and awareness and use of community-based distribution (CBD) agents;
- Attitudes toward adolescent reproductive health issues; and
- Knowledge about HIV/AIDS.

Among adolescents, a special section on premarital sexual activity and abortion were included.

### Procedures

**Questionnaires developed.** The KNIECSS provided a unique opportunity to gather data enabling comparison of views from adults and adolescents. Another important opportunity was to test new data collection methods, especially those designed to measure communication among couples, parents, and their children. It was necessary, therefore, to generate a sample of matched husband/wife pairs, as well as parent/young people pairs to assess communication in the dyad. These objectives necessitated five main samples:

- Male and female adolescents ages 10 to 14 (younger adolescents),
- Parents of these adolescents,
- Male and female adults age 20 and older (adults),
- Couples ages 20 and older (adult couples),<sup>1</sup> and
- Male and female adolescents ages 15 to 19 (older adolescents).

Separate questionnaires were designed for each subsample. In order to enable comparisons of responses, questions were reworded to reflect gender and age status. For example, while an adolescent would be asked: "Have you spoken to either of your parents about . . . ?," the parent would be asked: "Have you spoken to (name of child) about . . . ?" The questionnaires for the older adolescents and adults were largely identical. As much as possible, the questions were worded to enable direct comparison with the Kenya Demographic and Health Survey (KDHS) and among the various subsamples. For example, a question that was asked across all subsamples was worded the same way throughout. In addition, items were placed in the same sequence in each of the various questionnaires. All of the questionnaires were developed simultaneously. Many of the questions were generated from JHU/CCP's questionnaire data

<sup>1</sup> The husband/wife pair was generated from the sample of adults ages 20 and older. This was achieved by interviewing the husband and the wife simultaneously (but separately) in 20 percent of the households where adults ages 20 and older were to be interviewed. Just over 400 couples were successfully interviewed.

bank. Several drafts were developed and reviewed by experts in health communication before pretesting in the field began.

The questionnaires were pretested three times. The objective of the pretests was to provide information on the length of the interview, the clarity of the questions, and respondents' comprehension. The pretests also aimed at determining whether the questions on sexuality were acceptable to the younger adolescents. The first pretest was conducted over two days in July 1994, in predominantly middle- and low-income areas of Nairobi. As a result of the pretest, questions on sexual behavior were dropped from the younger adolescents' questionnaire, and questions on abortion were dropped from the adult (20 and above) questionnaire. The second pretest was conducted a few weeks later by the same interviewers. An added pretest of the questionnaires for the younger adolescents was conducted among parents to ascertain that the questions being asked, especially those pertaining to reproductive health, were acceptable and would not cause undue concern.

After the pretests, each questionnaire was translated into Swahili, Kikuyu, Luo, Luhya, Kamba, Kisii, Meru, Kalenjin, and Masai. One research assistant translated each questionnaire from English to the vernacular language (translations were done by bilingual research assistants, many of whom had translated the questionnaire for the KDHS). A second research assistant translated the vernacular back to English to check for any alteration in meaning. Discrepancies were reconciled by a discussion between the two research assistants. A neutral editor then reviewed the final vernacular version. Finally, the vernacular questionnaires were pretested among the interviewers during training. After revision, they were printed for data collection.

**Sample design.** The KNEICSS sample was drawn from the National Sample Survey Evaluation Programme (NASSEP III) master sample frame developed and maintained by the Central Bureau of Statistics (CBS). The sampling design that has been adopted is a 2-stage cluster design that is household-based. The survey was designed to mirror the 1993 KDHS.

The master sample comprises 1,048 rural and 329 urban clusters. The KNEICSS covered a total of 269 clusters—192 in rural areas and 77 in urban areas—of which 52 percent had been used in the 1993 KDHS. All districts were included with the exception of Tana River and Lamu districts in Coast Province; Isiolo and Marsabit districts in Eastern Province; Garissa, Mandera, and Wajir districts in North Eastern Province; and Elgeyo-Marakwet, Samburu, Turkana, and West Pokot districts in Rift Valley (see Appendix A and B). The excluded districts cover about 4 percent of the population and are mainly inhabited by a nomadic/pastoralist population, who have been hard for most surveys to reach. Roughly one-fourth of the clusters in each selected district were sampled for inclusion in the survey. Urban clusters were selected from the districts of Nairobi, Mombasa, Kisumu, Nakuru, Uasin Gishu, and Kiambu. Rural clusters were selected from 33 of the 35 districts (all of Nairobi and Mombasa were considered urban). The urban areas were over-sampled to allow sufficient sample sizes to compare with the follow-up survey planned after the IEC interventions. During the sampling, the government subdivided some of the districts to make new ones. The previous boundaries, however, are used in this report to enable comparison with the 1993 KDHS. The details regarding the number of clusters selected in each district are provided in Appendix B.

Within each selected cluster, the household lists from the NASSEP III were reviewed, and roughly 22 households were randomly selected. Because the NASSEP III has information about household structures, the sample was selected to maximize the likelihood of finding a respondent within the appropriate age range for the survey. Interviewers were instructed to make at least three visits to interview the selected respondent. If, after the third visit, the respondent was unavailable, they were instructed to select a respondent from the neighboring house.

**Recruitment and training of the survey personnel.** Given the similarity of the KNIECSS to the KDHS, the research team desired to use the same interviewers who had worked on the KDHS. In collaboration with CBS, NCPD identified 325 interviewers, supervisors, coordinators, and field editors who had participated in the KDHS or who had substantial, relevant experience. There were 240 interviewers, 41 supervisors, and 44 district coordinators involved in the fieldwork.

Training of the survey personnel was conducted in mid-August 1994 and was based on the interviewer's manual and the four sets of the questionnaire (the English and vernacular versions). Training was conducted by the research team, which included the Principal Investigator, the Assistant Principal Investigators, CBS and NCPD field coordinators, and JHU/CCP staff. The training consisted of a detailed review of each questionnaire and a thorough review of the interview procedures. Suggestions on how to deal with potential field problems were discussed. Role-playing was incorporated to ascertain comprehension of the survey instrument and interview procedure. The trainees also conducted practice interviews using the vernacular questionnaires to ensure systematic wording of the questions.

**Field work.** Data collection was implemented from the last week of August through the end of September 1994. The exercise was carried out under the management and supervision of CBS and NCPD field coordinators. The survey area was divided into groups of five to six districts, and the research team visited each district to supervise field work and to conduct spot-checks. Field editors reviewed questionnaires in the field and returned problem questionnaires requesting subjects be interviewed again. Supervisors assigned interview households and spot-checked a sample of interviews. The field coordinator oversaw the field logistics, including transportation, supplies, and payment of salaries, etc. They forwarded completed questionnaires to the survey office, where data were further edited and coded in preparation for data entry.

**Data processing.** Data processing took place from mid-September until the end of November 1994. Data were entered at NCPD headquarters using the Integrated System for Survey Analysis (ISSA) program, which had been used during the 1993 KDHS. ISSA has a data management mechanism that enables automatic skips and flags a questionnaire whenever there is inconsistency in the responses. Data entry was supervised by NCPD personnel, with technical assistance from JHU/CCP. Given the fact that the survey covered four different target groups, data were weighted using the inverse proportion of the sample weights to enable comparison with the national population.

Data were analyzed using the STATA 3.1<sup>®</sup> statistical package. Analysis was stratified by gender and by the various age-graded samples. Because the questionnaire for the 10 to 14 year-olds and their parents was deliberately abbreviated, only limited analysis is available for these groups. Where possible, results are compared with the 1993 KDHS. *All results are based on weighted data.*



## Chapter III. Characteristics of the Study Sample

### Demographic Characteristics

The Kenya National IEC Situation Survey (KNIECSS) collected data on 997 adolescents ages 10 to 14; 1,474 adolescents ages 15 to 19; 2,892 adults ages 20 to 54; and, 953 parents of adolescents ages 10 to 14 (see Table 3.1). Consistent with the national distribution of Kenyan residents, just over 80 percent of the sample were rural residents. The majority of the sample had some education, with women less likely to have attended school than men (see Figure 3.1).

KNIECSS results generally resemble those obtained by similar studies in terms of respondent's education, religion, and urban/rural residence (see Table 3.2). For example, 18 percent of the women ages 15 to 49 in the 1993 KDHS had no formal education, compared with 17 percent of those in the same age group in the KNIECSS. Roughly 91 percent of women in the KNIECSS were Christian, the same proportion as their counterparts in the KDHS. Just as 17 percent of women in the KNIECSS lived in urban areas and 83 percent in rural areas, 18 percent of women in the KDHS lived in urban areas and 82 percent in rural areas.

**Table 3.1**  
**Percent Distribution of Respondents by Selected Demographic Characteristics. Kenya, 1994**

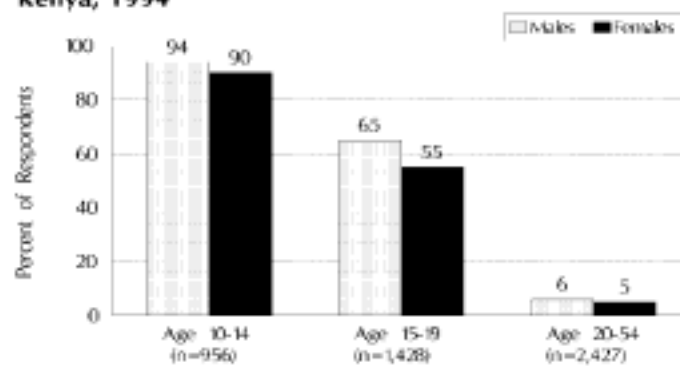
Demographic	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54		Parents of Adolescents 10 to 14	
Characteristic	Males (n=507)	Females (n=485)	Males (n=735)	Females (n=739)	Males (n=1416)	Females (n=1476)	Males (n=334)	Females (n=619)
<b>Residence</b>								
Urban	16.5	18.3	15.0	18.3	15.6	14.0	17.8	15.9
Rural	83.5	81.7	85.0	81.7	84.4	86.0	82.2	84.1
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of respondents	(507)	(485)	(735)	(739)	(1,416)	(1,476)	(334)	(619)
<b>Level of Education</b>								
None	1.1	5.7	1.1	3.0	9.8	21.0	15.1	31.2
Primary	96.9	92.1	69.9	73.6	50.4	51.7	60.9	53.1
Secondary	0.9	1.5	27.1	21.9	30.3	23.0	17.5	13.2
Post-secondary	0.0	0.0	1.6	0.7	7.7	3.3	6.1	1.5
Other <sup>a</sup>	1.1	0.7	0.3	0.8	1.8	1.0	0.4	1.0
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of respondents	(498)	(476)	(733)	(735)	(1,410)	(1,469)	(333)	(619)
<b>Religion</b>								
Protestant	53.4	57.8	56.8	59.9	54.2	59.2	51.7	54.7
Catholic	38.1	33.5	35.3	34.8	37.1	33.0	36.1	37.6
Moslem	5.1	6.2	4.9	3.8	4.3	3.8	5.1	5.1
Traditional/Other	1.4	1.6	1.3	0.9	1.3	1.8	2.6	1.1
No religion	2.0	0.9	1.7	0.6	3.1	2.2	4.5	1.5
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Number of respondents <sup>b</sup>	(507)	(481)	(735)	(737)	(1,410)	(1,475)	(334)	(619)

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Includes polytechnic or vocational institutions, formal or informal trade schools, etc.



**Figure 3.1.**  
**Respondents Currently Attending School,**  
**Kenya, 1994**



SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

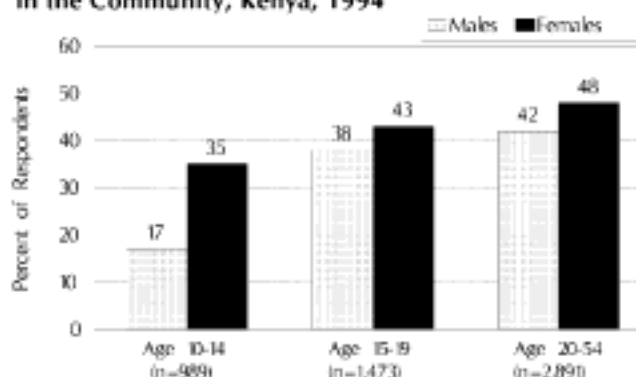
**Table 3.2**  
**Percent Distribution of Women Ages 15 to 49, by Selected**  
**Background Characteristics, 1994 KNIECSS and 1993 KDHS**

Background characteristic	Weighted percent	
	1994 KNIECSS	1993 KDHS
<b>Age</b>		
15-19	25.4	23.3
20-24	21.5	21.7
25-29	17.8	16.2
30-34	12.0	14.4
35-39	9.6	10.2
40-44	7.6	8.5
45-49	6.1	5.8
<b>Marital Status</b>		
Never married	31.7	30.2
Married	61.4	58.3
Widowed/divorced/separated	6.2	7.4
Living together	0.7	3.1
<b>Education</b>		
No education	16.9	17.9
Primary	56.4	57.6
Secondary and above	26.7	24.5
<b>Residence</b>		
Urban	16.8	17.8
Rural	83.2	82.2
<b>Religion</b>		
Catholic	34.6	31.4
Protestant/other Christian	56.7	59.8
Muslim	4.6	4.9
No religion	2.0	2.7
Other	1.1	1.0
<b>Province</b>		
Nairobi	8.0	6.7
Central	16.3	14.5
Coast	9.1	9.5
Eastern	18.2	18.6
Nyanza	18.3	15.4
Rift Valley	17.3	20.7
Western	12.8	14.5
<b>Total</b>	<b>100</b>	<b>100</b>

## Social Networks

In Kenya, social clubs provide an opportunity for people to interact and for communities to forge alliances. Clubs range from religious gatherings such as Bible study groups to commercial undertakings such as cooperative societies. Respondents in the survey were asked whether they belonged to any clubs or social organizations in the community. Those who answered affirmatively were asked to specify the organization. Results show that anywhere from one-third to just under one-half belong to some type of social club (see Figure 3.2). Women were more likely to belong to a club than men. For example, roughly 35 percent of adolescent females ages 10 to 14 belonged to a social club, compared with just 17 percent of males that age. Among older adolescents, 43 percent of females belonged to a club, compared with 38 percent of the males. Nearly one-half of adult women (48 percent) stated that they belonged to a club, compared with 42 percent of adult males. Religious groups appear to be the most popular clubs for all groups except adult women (see Table 3.4). Among adult women, the most common organization was a women's group—46 percent of women belonged to such a group, compared with 37 percent who belonged to a religious club. Other popular clubs included sports clubs, especially among males. Music clubs were also popular, especially among adolescent females. A significant proportion of adults also belonged to self-help clubs (16 percent of men and 10 percent of women).

**Figure 3.2.**  
Respondents Who Are Members of Social Clubs  
in the Community, Kenya, 1994



SOURCE: NCPD and JHU/CCP National IEC Situation Survey (1994).

**Table 3.3**  
Percent Distribution of Respondents by Social Club Membership,<sup>a</sup>  
Kenya, 1994

Type of Club	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males (N=99)	Females (N=159)	Males (N=275)	Females (N=288)	Males (N=571)	Females (N=613)
Religious	23.6	42.0	27.3	36.4	30.1	36.7
Sports	24.1	4.9	25.3	7.1	19.0	0.0
Music	23.4	40.2	12.5	30.9	0.0	0.0
Women's club	0.0	0.0	0.0	0.0	5.1	46.3
Boy Scouts/Girl Guides	9.7	5.5	2.8	1.8	0.0	0.0
School (unspecified)	8.8	4.1	8.2	6.1	0.0	0.0
Youth Club	4.4	8.0	13.4	13.7	4.9	2.7
Community (unspecified)	0.0	0.0	0.0	0.0	16.8	11.5
Self-help	0.0	0.0	0.0	0.0	15.6	10.0
Savings	0.8	0.0	0.7	0.7	5.1	1.6
Farmers	3.0	6.9	3.5	1.5	2.3	0.5
4-K	10.5	4.5	7.6	3.6	0.0	0.0
Drama	0.0	0.0	2.2	4.4	0.0	0.0
Men's club	0.0	0.0	0.0	0.0	1.5	0.3
Jua Kali	0.0	0.0	1.0	0.0	1.0	0.1
Other <sup>b</sup>	3.5	5.1	9.6	11.9	13.2	9.2

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTES: <sup>a</sup> Among those who belong to a club, multiple club membership possible, percentages may exceed 100.

<sup>b</sup> Includes Red Cross, marriage encounter, creative groups, and other unspecified community organizations.

## Marital Status and Fertility

In-depth questions on marriage and fertility were confined to older adolescents (ages 15 to 19) and adults (see Table 3.4). As expected, most adolescents were unmarried—99 percent of males and 88 percent of females. Of the adolescent females who were married, 74 percent were in monogamous marriages, while 26 percent were in polygamous marriages. (The number of married adolescent males was too small to make definitive statements about the nature of the polygamous relationships.) Roughly 15 percent of adolescent females, regardless of their marital status, had children, and the mean number of living children was 1.3 (0.7 boys and 0.6 girls). At the time of the interview, 4 percent of all adolescent females were pregnant.

**Table 3.4**  
**Percent Distribution of Respondents by Marital Status and Fertility, Kenya, 1994**

Characteristic	Adolescents 15 to 19		Adults 20 to 54	
	Males	Females	Males	Females
<b>Marital Status</b>				
Never married	98.5	87.8	20.7	12.5
Married	1.4	10.8	74.6	80.3
Cohabiting	0.0	0.6	0.5	1.0
Divorced/Separated	0.1	0.8	4.2	6.2
TOTAL	100.0	100.0	100.0	100.0
Number of respondents	(734)	(739)	(1,413)	(1,474)
<b>Type of Marriage <sup>a</sup></b>				
Monogamous	65.0	74.2	90.0	81.4
Polygamous	35.0	25.8	10.0	18.6
2 wives	-----	57.8	52.3	57.8
3 wives	-----	35.2	28.8	28.5
More than 3 wives	-----	7.0	18.9	13.7
TOTAL	100.0	100.0	100.0	100.0
Number of respondents	(13) <sup>b</sup>	(80)	(1,045)	(1,124)
<b>Have any children?<sup>c</sup></b>				
Yes	1.4	14.5	77.0	88.4
No	98.6	85.5	23.0	11.6
TOTAL	100.0	100.0	100.0	100.0
Number of respondents	(733)	(739)	(1,408)	(1,470)
<b>Currently pregnant?<sup>d</sup></b>				
Yes	3.0	3.8	8.7	7.8
No	97.0	96.2	91.3	92.2
TOTAL	100.0	100.0	100.0	100.0
Number of respondents	(654)	(731)	(1,379)	(1,470)
<b>Mean number of children<sup>e</sup></b>				
All	-----	1.3	4.3	3.9
Boys	-----	0.7	2.1	2.0
Girls	-----	0.6	2.2	1.9
Number of respondents	-----	(103)	(1,053)	(1,273)

SOURCE: NCPD and JHU/CCP: Kenya National IEC Situation Survey (1994).

NOTES: <sup>a</sup> Among married respondents, excluding those who do not know whether partner has other wives (2.1 percent for adolescents; 2.7 percent for adults).

<sup>b</sup> Only 13 males ages 15 to 19 were married; interpret results with caution. Only 3 were in polygamous marriages (data not analyzed).

<sup>c</sup> Among all respondents.

<sup>d</sup> Men were asked if wife/partner was currently pregnant. For polygamous marriages, men were asked about most recent wife.

<sup>e</sup> Among those who have children. Data for adolescent males not analyzed due to small sample.

Marital and fertility results for the adult subsample are also presented in Table 3.4. Only 21 percent of all adult males and 13 percent of all adult females had never married. Among those who were married, 90 percent of all adult males and 81 percent of all adult females were in monogamous relationships. Adult females were twice as likely to be in polygamous relationships as males, 19 percent *versus* 10 percent. Seventy-seven percent of all adult males and 88 percent of all adult females had children, and the mean number of children was 4.3 for males *versus* 3.9 for females. At the time of the interview, 9 percent of all adult males reported their partners were pregnant and 8 percent of women said they were pregnant.



## Chapter IV. Mass Media Habits

In Kenya, a wide array of mass media initiatives—radio and television programs, and educational information in newspapers, posters, pamphlets, and other print materials—motivate couples to use family planning by informing them about methods and the advantages of fertility regulation. The appeal of mass media is that it can reach large audiences at a lower cost than interpersonal communication. Data from the 1989 KDHS demonstrate the impact of IEC via mass media—women exposed to family planning messages via radio, print, and television were three times as likely to be using contraception as were women not exposed (Westoff and Rodríguez, 1995). For these reasons, the mass media habits of survey respondents were an important topic. Respondents were asked how often they used four main types of mass media—print media, radio, television, and cinema.

### Print Media Habits

**Newspaper readership.** Survey results suggest that appreciable proportions of the respondents read newspapers (see Table 4.1). The most widely read newspaper was *The Nation*—at least 70 percent of the readers said this was the paper they usually read. This was followed by *Taifa Leo* and *The Standard*, each read by one third of all newspaper readers. When asked whether they ever read newspapers, 23 percent of younger adolescents said they did. This trend rose sharply among older adolescents, with significant gender differentials—61 percent of males versus 44 percent of females said they read the newspaper. Among adults, three-fourths of males and one-third of females said they read newspapers. These high rates of readership can be expected—newspapers are widely shared among friends and family members. Newspapers also are an important part of the mornings' routine in most offices. They are also recycled for other purposes such as wrapping foodstuffs, thereby reaching audiences who may not normally purchase them.

Although many respondents read newspapers, the majority read it only one to three days a week (see Table 4.1). Adult males read newspapers most frequently—23 percent said they read it daily. Among those who read newspapers, roughly 20 percent to 34 percent had read one the previous day or on the day of the interview. Of interest is the finding that adolescents ages 10 to 14, especially females, reported as high a readership as adults. The reason for this is unclear.

**Table 4.1 Percent Distribution of Respondents by Newspaper Readership Patterns, Kenya, 1994**

Newspaper Readership	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20-24	
	Males (N=507)	Females (N=485)	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
Ever read newspaper:	22.6	22.8	60.8	44.0	72.5	34.1
Among those who read:						
Read every day	5.3	7.3	7.4	8.9	22.8	14.3
4-5 days/week	5.8	4.7	6.9	4.9	8.7	5.0
1-3 days/week	63.4	61.0	52.8	54.0	50.1	47.5
Less often	25.5	27.0	32.9	32.2	18.4	33.2
Total	100.0	100.0	100.0	100.0	100.0	100.0
Among those who read <sup>a</sup> :						
Read yesterday or today	23.7	30.0	20.2	19.7	33.5	21.8
Among those who read, newspaper usually read:						
<i>The Nation</i>	69.7	88.5	83.5	81.6	81.3	82.6
<i>Taifa Leo</i>	47.1	31.5	35.2	35.8	30.6	28.4
<i>The Standard</i>	28.1	9.4	32.0	33.1	34.8	30.9
<i>The Kenya Times</i>	8.7	3.8	15.2	12.4	20.5	9.4
<i>Coast Weekly</i>	0.0	0.0	0.1	0.6	0.0	0.0

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).  
<sup>a</sup>Multiple newspapers possible, percentages may add to more than 100.0

**Magazine readership.** Respondents also were asked whether they ever read magazines. Magazine readership ranged from 14 percent among younger adolescent males to about 40 percent among adolescent and adult males (see Table 4.2). There were substantial gender and age differences in readership. For example, while readership among adolescent males (15-19) was the same as readership among adult males, readership among adolescent females (15-19) was twice as high as their adult counterparts. Most respondents read magazines once a month with less than 15 percent reading magazines four or more times a month.

As expected, the magazine of choice varied by age groups. Younger adolescent males favored the *Pied Crow*, *Weekly Review*, and *Parents*, in that order. Younger adolescent females preferred *Parents*, followed by *True Love* and *Pied Crow*. Older adolescent males preferred *Weekly Review*, followed by *True Love* and *Drum*. Their female counterparts favored *Parents*, followed by *True Love* and *Drum*. The pattern for adult males was close to the older adolescent males—*Weekly Review*, followed by *Parents* and *Drum*. Among adult women, *Parents* was the clear favorite magazine with 65 percent citing it as the one they read most.

**Table 4.2**  
**Percent Distribution of Respondents by Magazine Readership Patterns, Kenya, 1994**

Magazine Readership	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males (N=506)	Females (N=481)	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
<b>Read magazines</b>	14.2	18.9	42.3	38.9	41.2	19.8
<b>Among those who read, how often per month:</b>						
Four or more times	8.0	12.7	11.4	13.2	14.8	7.9
3 times	13.4	10.0	9.3	12.5	8.3	8.2
2 times	7.8	19.9	17.5	14.5	19.2	15.4
Once per month	67.0	52.7	60.8	56.0	55.1	64.0
Hardly ever	3.8	4.7	1.0	3.8	2.6	4.5
<b>Among those who read, favorite magazine read:<sup>a</sup></b>						
<i>Parents</i>	6.3	16.7	20.1	37.3	39.8	65.4
<i>Weekly Review</i>	13.6	6.7	30.7	14.4	40.6	16.1
<i>Drum</i>	5.9	8.3	22.0	23.3	21.4	21.0
<i>True Love</i>	4.1	11.7	22.6	30.6	20.2	21.9
<i>Pied Crow</i>	28.1	11.3	17.0	8.7	0.0	0.0
<i>Step</i>	3.5	5.4	9.5	9.1	11.9	14.9
<i>Society</i>	0.0	0.0	3.0	1.7	5.7	0.3
<i>Today in Africa</i>	0.0	0.0	2.3	0.4	2.7	3.3
<i>Times</i>	0.0	0.0	3.0	1.7	5.7	0.3

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey, 1994

NOTE: <sup>a</sup> Multiple magazines possible and percentages may not total 100. Unlisted magazines read by less than 2 percent of the respondents are omitted.

## Radio Habits

Respondents were asked whether they or someone in their household owned a radio. Roughly two-thirds of respondents lived in homes that had radios. All females except those in the 15 to 19 age group were less likely than males to live in households with radios (see Table 4.3). The sample appeared to have higher levels of radio ownership than that reported in the 1993 KDHS. For example, among female respondents ages 15 to 49 in the KNIECSS, 65 percent lived in homes that had radios, while 52 percent of the same age group reported so in the 1993 KDHS.



**Frequency of listening.** All respondents were asked how often they listened to the radio because even if they did not own a radio, they may have access to a radio through friends or through public places, such as restaurants, markets, or shops. Anywhere from one- to two-thirds of the sample said they listen to the radio daily (see Table 4.3). Adolescent girls ages 10 to 14 were the least likely to listen to the radio daily (35 percent reported listening daily) and adult men were the most likely (67 percent reported listening daily).

**Listening times for radio.** Among those who listened to the radio, the most popular listening time was between 6:00 p.m. and 8:00 p.m. for both groups of adolescents and adult women. The favorite listening time for adult men was from 8:00 p.m. until the station ended its broadcast day. These choices may be reflective of social behavior in Kenya. In Kenya, news is broadcast on the radio at 7:00 p.m. and 9:00 p.m. Women are likely to be home preparing evening meals by 7:00 p.m., and, therefore, more likely to be listening to the earlier news broadcast. Men, however, may arrive home later and may be more likely to listen to the later news broadcast and subsequent programming. After the evening times, the most popular listening time was early morning between 6:00 a.m. and 8:00 a.m. This period also brackets the 7:00 a.m. national news, which has a popular following.

**Table 4.3**

**Percent Distribution of Respondents by Radio Ownership and Listenership, Kenya, 1994**

	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males (N=506)	Females (N=481)	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
<b>Radio Ownership &amp; Listenership</b>						
Have radio in house	67.0	62.6	71.8	72.0	70.1	62.5
<b>Listen to radio how often?<sup>a</sup></b>						
Daily	40.4	35.0	53.0	44.8	66.5	48.3
A few days per week	16.4	12.7	14.0	14.5	10.7	9.4
About once per week	5.5	5.3	9.4	6.5	6.6	5.6
About once per month	1.4	2.1	3.5	1.6	2.2	3.8
Only on weekends	3.4	4.0	2.6	4.9	1.2	1.5
Only during holidays	2.2	2.3	2.7	2.9	0.1	0.7
Other	0.4	1.1	0.9	0.7	0.5	1.7
Hardly ever	30.3	37.5	13.9	24.1	12.2	29.0
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0
<b>Among those who listen to the radio, times most listen:<sup>b</sup></b>						
6 am to 8 am	27.0	20.3	33.3	20.7	45.1	31.0
8 am to 10 am	15.3	23.7	14.6	19.3	11.6	21.0
10 am to 12 noon	9.6	6.9	7.2	9.5	5.8	7.0
12 noon to 2 pm	17.1	12.0	20.6	21.4	22.1	19.5
2 pm to 4 pm	8.2	10.3	9.9	12.9	5.6	6.6
4 pm to 6 pm	17.4	22.6	20.6	16.2	17.5	14.7
6 pm to 8 pm	44.4	40.7	46.2	38.7	46.5	39.4
8 pm to end of broadcast day	27.6	21.8	38.5	35.4	52.2	30.4
<b>All the time</b>	<b>3.0</b>	<b>3.3</b>	<b>5.9</b>	<b>6.2</b>	<b>7.7</b>	<b>8.0</b>

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey, 1994

NOTES: <sup>a</sup> Among all respondents, to include those who may not have a radio at home but have access to one elsewhere.

<sup>b</sup> Multiple listening times possible, percentages total to over 100. Variable excludes those who "hardly ever" listen to radio.

**Types of programs and language preference.** Respondents who reported listening to the radio were asked what station they listen to and results show that the KBC Kiswahili broadcast (National Service) is by far the most popular station (see Table 4.4). Roughly 20 percent to 40 percent also listen to the English channel (General service) and just over 33 percent listen to various vernacular language channels. At the time of

the field work, the FM radio stations were not operational.

When asked what language they prefer to listen to on the radio, over 60 percent of listeners in all groups chose Kiswahili-language broadcasts. Less than 20 percent preferred English broadcasts, and even fewer preferred the other vernacular languages.

Respondents were asked to name the radio programs they prefer. Because some respondents did not know the names of some programs, most shows were collapsed into the categories listed in Table 4.4. Among younger adolescent boys, most listened to news, children's, and music programs. Among younger adolescent girls, most listened to children's programs, news, and music programs. It is worthwhile to note that many 10- to 14-year-olds cited the "other" category, which includes "don't know/can't recall," therefore these data should be interpreted cautiously.

**Table 4.4**  
**Percent Distribution of Respondents by Favorite Radio Stations, Languages, and Programs, Among Those Who Listen to Radio.<sup>a</sup> Kenya, 1994**

Radio Listenership	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males (N=345)	Females (N=292)	Males (N=625)	Females (N=552)	Males (N=1,214)	Females (N=1,035)
<b>Station listened to</b>						
KBC Kiswahili	75.6	85.9	87.5	85.3	91.0	85.1
KBC English	20.8	16.5	41.7	37.0	37.3	19.8
KBC Vernacular	40.2	37.0	34.9	36.1	36.1	42.4
<b>Language preference</b>						
Kiswahili	61.7	66.2	68.6 <sup>b</sup>	65.1	70.8	62.0
English	10.9	7.4	18.3	18.3	16.4	7.7
Kikuyu	7.4	8.1	3.6	5.8	4.6	11.4
Luo	5.9	4.8	3.2	5.1	2.7	5.6
Kalenjin	4.1	3.2	2.3	1.6	1.3	3.5
Kamba	2.5	3.3	2.0	1.7	1.2	2.6
Kisii	4.4	2.8	0.4	1.0	0.9	2.6
Luhya	0.0	2.6	0.4	0.4	1.1	2.6
Other <sup>c</sup>	3.2	1.6	1.2	1.0	1.0	2.0
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0
<b>Program most listen to:</b>						
News	19.7	12.6	22.6	14.3	33.1	23.6
Music	11.4	8.1	14.7	13.8	12.6	7.9
Children's programs	12.2	23.4	2.8	5.8	0.5	0.8
Salaams	5.7	3.4	7.0	5.6	6.6	5.3
<i>Kuelewana</i> /Family planning/ <i>Afya Bora</i>	0.0	0.0	8.0	8.6	24.5	36.3
Educational programs	7.1	6.6	6.0	8.6	0.0	0.0
Radio theater	4.1	4.2	5.3	7.0	1.8	4.6
Religious program	1.4	5.2	2.8	11.1	4.6	8.1
Je Huu Ni Ungwana	4.3	4.5	4.9	4.9	9.4	6.2
Commercials/advertisements	4.3	3.1	5.8	2.7	2.2	3.0
Sports	2.7	2.9	4.3	1.4	2.2	0.8
Other <sup>d</sup>	27.1	26.0	15.8	16.2	2.5	3.4
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTES: <sup>a</sup>Excludes those who "hardly ever" listened to radio.

<sup>b</sup>Multiple responses possible, percentages may add to more than 100.

<sup>c</sup>Other languages mentioned by less than 2 percent of participants.

<sup>d</sup>Includes "don't know/can't recall."

Patterns for older adolescents differed among males and females. The most listened-to programs for males were news, music, and health programs. Among females, the most listened-to programs were health programs, news, and music programs. The pattern for adult males mirrored that of the older adolescents. Of particular interest to the research was exposure to the JHU/CCP-sponsored radio program, *Kulewana ni Kuzungumza* (also called *Haki Yako*).<sup>2</sup> Some respondents spontaneously mentioned this show by name as the program they listen to most. For example, 8 percent of older adolescent males and 6 percent of older adolescent females reported *Kulewana ni Kuzungumza* to be the program they listen to most. Among adults, 12 percent of men and 16 percent of women reported the same program.

**Where people listen to the radio.** Respondents who listened to the radio regularly were asked where they listened to the radio. Most people—80 percent or more—listened to the radio at home (see Table 4.5). Between 13 percent and 19 percent of respondents listened at a neighbor's or friend's house. This was especially the case for males—while 18 percent of adult males listen to the radio at a friend's or neighbor's house, only 13 percent of their female counterparts reported doing so. A small portion listened at school, shop, market, or some commercial outlet.

**Table 4.5**  
**Percent Distribution of Respondents Who Listen to the Radio by Where They Listen to It, Kenya, 1994**

Location	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males (N=345)	Females (N=292)	Males (N=625)	Females (N=662)	Males (N=1,214)	Females (N=1,035)
At home	83.1	84.9	79.5	86.9	80.9	86.7
At neighbors/friend's home	13.6	16.1	18.7	13.1	17.5	13.1
At school	4.7	8.3	4.7	4.6	1.8	0.2
At a shop, market, or similar commercial place	4.3	1.7	4.4	0.7	7.1	1.1
At work	0.2	1.1	1.2	0.9	3.8	1.5
In a car, matatu, or other vehicle	0.0	0.0	0.1	1.9	1.2	1.3

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTE: Multiple responses possible, percentages add up to more than 100 percent. Calculations exclude those who "hardly ever" listen to radio.

## Television Habits

**Access.** Respondents were asked several questions to assess their television habits. Anywhere from 9 percent to 16 percent of respondents resided in homes where there was a television (see Table 4.6). Thus, television is a relatively rare item in the majority of households.

**Frequency, time, and types of programs watched.** All interviewees were asked how often they watch television regardless of whether they owned a television, because people could possibly watch broadcasts elsewhere. Results suggest that less than 12 percent of the sample watch television every day. The greater majority, over 63 percent, seldom watch television (see Table 4.6).

At the time of the survey, Kenya had two main television stations—KBC and Kenya Television Network (KTN). KBC is the larger of the two and transmits nationwide. KTN is limited to the Nairobi area. Results show that among those who watch television, over 90 percent watch KBC. Less than 22 percent of television viewers said they watched KTN (see Table 4.6). Among the Nairobi respondents, however, anywhere from 42 percent to 63 percent said they watched KTN.

<sup>2</sup> A more detailed analysis of exposure to this program is presented in Chapter 6 and in the report by Kim *et al.*, 1996.

Respondents who watched KBC and KTN were asked what times they usually watched television<sup>3</sup>. The majority of KBC viewers watch between 8:00 p.m. and 9:00 p.m. The second most popular viewing time was between 7:00 p.m. and 8:00 p.m., across all age groups. The third most popular time varied for the youngest adolescents, however, it was split evenly between 6:00 p.m. to 7:00 p.m. and 9:00 p.m. to 10:00 p.m. Among older adolescents and adults, the third most popular time was between 9:00 p.m. and 10:00 p.m. KTN viewership results show that for younger adolescents, the favorite viewing time was from 7:00 p.m. to 8:00 p.m., while for older adolescents and adults, it was from 8:00 p.m. to 9:00 p.m. (see Table 4.6).

<sup>3</sup> Due to an omission in the questionnaire, television viewership before mid-day was not recorded.

**Table 4.6**  
**Percent Distribution of Respondents by Television Ownership and Time and Frequency of Viewership, Kenya, 1994**

Television Habit	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males (N=507)	Females (N=485)	Males (N=736)	Females (N=741)	Males (N=1,416)	Females (N=1,476)
<b>Have a television at home</b>	8.6	12.9	12.4	12.2	15.5	12.1
<b>How often watch television<sup>a</sup></b>						
Daily	4.7	10.4	6.8	7.8	11.5	6.4
A few days per week	8.3	4.4	7.4	4.3	7.8	2.3
At least once per week	6.7	3.2	11.4	4.9	7.5	3.5
At least once per month	1.5	3.8	6.0	5.1	6.7	4.3
Only during weekends	1.3	2.0	1.7	2.7	1.1	0.9
Only during the holidays	2.1	2.4	1.3	3.8	1.3	1.3
Other	0.6	0.0	1.6	1.5	1.7	0.8
Hardly ever	74.8	73.8	63.8	69.9	62.5	80.5
Total	100.0	100.0	100.0	100.0	100.0	100.0
<b>Channels watched<sup>b</sup></b>						
KBC	97.4	90.2	96.2	97.4	96.6	97.1
KTN (all respondents)	19.6	20.8	6.9	12.6	22.4	13.9
<b>Times KBC watched most<sup>b</sup></b>						
12 to 1 pm	(3.3)	4.9	3.8	6.2	1.1	5.4
1 to 2 pm	5.0	1.9	2.5	12.4	2.4	4.6
2 to 3 pm	11.8	8.4	7.0	10.2	2.9	9.3
3 to 4 pm	7.7	11.3	5.4	13.5	3.4	7.0
4 to 5 pm	15.4	31.0	16.7	17.7	7.7	12.0
5 to 6 pm	14.0	9.5	14.5	15.0	10.1	13.4
6 to 7 pm	16.3	10.4	18.9	21.2	21.1	24.5
7 to 8 pm	39.5	36.0	49.5	40.2	49.6	45.8
8 to 9 pm	50.1	36.8	49.5	40.2	49.6	45.8
9 to 10 pm	16.4	10.3	31.0	23.6	31.0	30.3
10 to station closing	3.6	6.9	1.02	11.2	13.6	13.5
All the time	(2.3)	7.7	1.7	5.6	3.0	3.0
<b>Times KTN watched most<sup>b</sup></b>						
12 to 1 pm	(15.1)	(7.9)	(11.0)	(1.7)	(5.4)	(3.4)
1 to 2 pm	(18.7)	(9.7)	(11.1)	(0.0)	(6.0)	(6.7)
2 to 3 pm	(10.9)	(9.7)	23.0	(3.7)	8.0	(3.3)
3 to 4 pm	(0.0)	(18.4)	(11.1)	(5.4)	(3.6)	(3.6)
4 to 5 pm	(7.5)	(0.0)	(7.4)	(10.4)	10.5	(5.6)
5 to 6 pm	(12.4)	(3.7)	(9.8)	(10.8)	(4.3)	(4.3)
6 to 7 pm	(20.8)	(17.6)	(11.1)	23.9	17.5	18.9
7 to 8 pm	43.4	28.9	33.3	28.7	36.7	19.5
8 to 9 pm	42.3	25.4	51.0	51.4	46.6	40.8
9 to 10 pm	10.3	19.4	37.3	24.0	40.9	29.3
10 to station closing	0.0	0.0	(14.0)	(8.7)	20.9	11.1
All the time	(4.7)	(9.6)	(6.0)	13.5	(4.1)	10.3

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTES: ( ) Less than 5 observations in denominator, interpret with caution.

<sup>a</sup> Among all respondents, to include those that may not have television at home but watch elsewhere.

<sup>b</sup> Among those who watch television. Multiple responses possible, percentages may add up to more than 100.

Excludes those who "hardly ever" watch television. Due to an omission in the questionnaire, television viewership before mid-day was not recorded

**Where people watch television.** Respondents who reported watching television were asked where they usually watched it. Results show that television viewership, unlike radio listenership, is a communal activity—the majority of respondents, regardless of age, watch television at a neighbor's or a friend's house

(see Table 4.7). The second most popular location for all males is commercial outlets,<sup>4</sup> while for all females it is at home.

**Table 4.7**  
**Percent Distribution of Television Viewers by Where They Watch Television, Kenya, 1994**

Location of Television	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males	Females	Males	Females	Males	Females
	(N=152)	(N=126)	(N=726)	(N=733)	(N=1,391)	(N=1,466)
Neighbor's/friend's home	47.8	42.4	39.8	37.1	38.5	41.2
Commercial outlets	26.8	18.1	25.6	11.3	28.7	13.8
Home	20.6	38.0	15.7	35.6	25.8	42.3
School	2.6	2.4	11.6	10.2	3.2	1.9
Work	0.2	0.7	1.5	(0.8)	6.7	(1.5)

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTES: ( ) Less than 5 observations in denominator, interpret with caution.  
Multiple responses possible, so percentages may not total 100 percent.  
Other sources mentioned by less than 2 percent of respondents

## Cinema Habits

Cinema is a medium JHU/CCP has used to reach the public in several countries with positive health messages. Cinema, like television, can reach audiences with positive health messages. To explore the possible use of this medium in Kenya, respondents were asked how many times they had gone to a cinema<sup>5</sup> in the month before the survey. Results show that cinemas are not a common part of many people's lives, reaching only a fraction of the population (see Table 4.8). Cinemas are most likely to reach males ages 15 to 19, and least likely to reach adult women.

**Table 4.8**  
**Percent Distribution of Respondents by Number of Visits to the Cinema in the Past Month, Kenya, 1994**

Number of Visits	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54	
	Males	Females	Males	Females	Males	Females
	(N=507)	(N=485)	(N=735)	(N=739)	(N=1,416)	(N=1,476)
Once	13.1	5.7	15.3	6.6	11.0	5.6
Twice	2.3	4.0	4.0	3.1	2.8	2.2
3 times	1.5	0.4	2.1	1.2	1.7	0.0
4 times or more	1.6	0.4	4.3	1.1	3.5	1.1
Not gone	81.5	89.5	74.3	88.0	81.0	91.1
<b>Total</b>	100.0	100.0	100.0	100.0	100.0	100.0
		0	0	0		

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

## General Exposure to Family Planning Messages

To explore the extent of exposure to family planning message in the mass media, respondents were asked if they had heard/seen any messages about family planning on radio, in newspapers, and in other print materials in the six months preceding the interview. This question was excluded in the 10-14 age group questionnaire.

<sup>4</sup> Many electronic repair or sales shops, especially in urban areas, have televisions and radios broadcasting throughout the day. At any time, a large group of men can be found gathered around, watching or listening.

<sup>5</sup> In Kenya, most cinema houses charge an admission price, which can range from \$1.00 to \$2.00 or more. There are also local mobile vans that show films to the public as the vans move from locale to locale. These are usually free.

Results revealed that the majority of respondents had heard a message about family planning on radio or print materials. For example, 83 percent of adult males, 76 percent of adult females, 65 percent of adolescent males, and 61 percent of adolescent females had been exposed to family planning messages on the radio (see Table 4.9). Data also suggest that regardless of the medium, adult males were most likely to have been exposed to family planning messages.

**Table 4.9**  
**Percent of Older Adolescents and Adults Who Were Exposed to Family Planning Messages,**  
**by Channel of Exposure, Kenya, 1994**

Channel of Exposure	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=736)	Females (N=741)	Males (N=1,416)	Females (N=1,476)
Radio	65.2	60.5	82.8	76.4
Posters	47.6	44.6	59.9	48.0
Newspapers/magazines	35.8	26.0	53.4	21.3
Pamphlets/leaflets	33.5	28.9	44.3	29.9
Billboards/signboards	21.0	19.8	30.4	20.9

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).  
Multiple responses possible, percentages exceed 100 percent

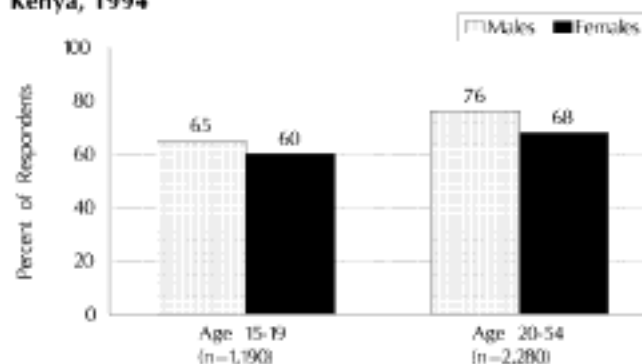
## Exposure to Other IEC Initiatives

As discussed earlier, JHU/CCP has been involved in family planning education in Kenya since 1984. It has assisted governmental and nongovernmental organizations to develop and implement a variety of reproductive education programs aimed at couples, health care providers, policy makers, community leaders, parents, and adolescents. At the time of the KNIECSS, a number of these initiatives were underway, and the survey provided an opportunity to assess public awareness of those activities.

### *Kuelewana ni Kuzungumza*.

The Client and Provider IEC Project, implemented in collaboration with NCPD and the Family Planning Association of Kenya (FPAK), produced a 30-minute radio drama in Kiswahili, called *Kuelewana ni Kuzungumza*.<sup>6</sup> Survey respondents were asked if they had heard about the radio program in the six months preceding the survey. Results show that the majority had heard the program, and the adult men group was the most likely to have heard it (see Figure 4.1).

**Figure 4.1.**  
**Respondents Who Heard *Kuelewana ni Kuzungumza*, Kenya, 1994**



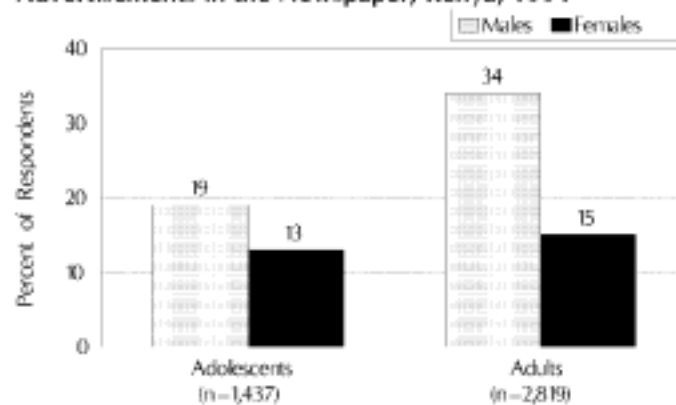
SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

<sup>6</sup> *Kuelewana ni Kuzungumza* is a Kiswahili saying which means roughly “Understanding comes from communicating.” The program was part of the *Haki Yako* campaign. *Haki Yako* is Kiswahili for “It is your right.”

### Vasectomy Promotion Campaign.

During the year before the KNIECSS, JHU/CCP collaborated with NCPD and Innovative Communication Services (ICS) to inform couples about vasectomy as a method of family planning. Over several months, the campaign placed advertisements in *The Nation*, *The Standard*, *The Kenya Times*, and *Taifa Leo* newspapers. During the survey, respondents were asked if they had seen these advertisements. Between 13 percent and 34 percent of the respondents said they had seen them (see Figure 4.2). The target of the campaign, adult men, were the most likely to have seen the advertisements. When limited to those who read newspapers, 45 percent of adult males had seen the advertisements compared with 37 percent of adult females, 29 percent of adolescent males, and 23 percent of adolescent females (data not shown).

**Figure 4.2.**  
**Respondents Who Saw Vasectomy Promotion Project Advertisements in the Newspaper, Kenya, 1994**



SOURCE: NCPD and JHU/CCP, Kenya National IEC Situation Survey (1994).

**More Time.** Before the fieldwork for the KNIECSS, JHU/CCP launched a full-feature Zimbabwean film, *More Time*. *More Time* revolves around a 15-year old girl growing up amid the usual teenage dilemmas of school, boys, alcohol, and other problems associated with adolescence. The film premiered in Nairobi, and was to be released into other cities later. At the time of the survey, however, it had only been shown in Nairobi. To assess exposure to the movie, all respondents were asked whether or not they had seen the film. Results show that only a fraction had seen the movie: among adolescents ages 10 to 14, only 2 percent had seen the film, compared with 3 percent of adolescents ages 15 to 19 and 2 percent of adults. This is consistent with earlier results that cinema is not a frequent communication medium in the study population.





## Chapter V. Family Planning Knowledge, Attitudes, and Practices

### Family Planning Awareness

To assess family planning awareness, respondents in the older adolescent and adult subsamples were asked if they had heard the term “family planning.”<sup>7</sup> Those who answered “yes” were classified as having spontaneous awareness of family planning. For those who had not heard this term, the interviewer rephrased the question by asking if the respondent had heard of “methods that can be used to delay or prevent pregnancy.” Respondents who answered “yes” were classified as having assisted awareness. Results show high levels of family planning awareness among both adults and adolescents (see Table 5.1). The study also found that males were more likely to be aware of family planning than females.

**Table 5.1 Percent Distribution of Respondents by Awareness of Family Planning, Kenya, 1994**

Awareness Level	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,407)	Females (N=1,468)
Spontaneous awareness	83.4	76.3	92.7	89.2
Assisted awareness	6.6	10.5	4.7	7.0
Had not heard of family planning	10.0	13.2	2.6	3.8

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

**Source of information about family planning.** The main source of family planning information for both male and female adolescents was radio (65 percent for males and 50 percent for females). Other sources for these groups include school and friends (see Table 5.2). There were interesting differences in sources of information among adults. Men cited radio as their main source of information, followed by health care facilities and friends. The sources were almost reversed for adult women—health care facilities were the main sources of information, followed by radio and friends. Appreciable numbers of both adult and adolescent males also cited public meetings, newspapers, and pamphlets/posters as sources of family planning information, but few of their female counterparts cited these sources.

<sup>7</sup> Due to the sensitivity of the issues, questions pertaining to family planning were limited to older adolescents ages 15-19 and adults ages 20 and above. Therefore, no data is available for younger adolescents or their parents.

**Table 5.2 Percent Distribution of Respondents by Sources of Information about Family Planning. <sup>a</sup> Kenya, 1994**

Source of Information	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=659)	Females (N=631)	Males (N=1,366)	Females (N=1,411)
Radio	64.9	50.4	78.4	44.9
Health worker/family planning provider	19.2	33.2	41.9	78.3
Friends	32.1	37.1	30.0	34.5
School	45.5	39.2	16.8	7.6
Newspaper	17.4	9.6	21.5	5.5
Public meetings	10.1	8.0	26.0	15.2
Pamphlet/poster	14.2	8.8	14.7	6.2
CBD Agent	6.1	5.1	12.7	9.5
Television	9.1	5.5	11.7	4.6
Relatives	6.4	16.7	6.5	8.4
Spouse/partner	0.8	2.0	5.8	3.2
Other	6.4	4.0	4.8	4.0
Nowhere	0.7	1.4	1.4	0.6

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Among those who have heard of family planning. Multiple sources possible, percentages may exceed 100.

## Family Planning Knowledge

**Knowledge about pregnancy prevention.** General knowledge about pregnancy prevention was measured by the response to five statements about reproductive health issues. Each statement was read aloud to the respondent, and the respondent could respond “true, false, or do not know.” Three of the statements were included in both adolescent and adult questionnaires, and an additional two items were asked of adolescents (see Table 5.3).

**Table 5.3. Percent of Respondents Who Responded “True” to Statements about Pregnancy Prevention. Kenya, 1994**

Statement	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
<i>If a woman takes two birth control pills just before sex, she can still become pregnant.</i>	17.9	20.9	21.7	29.1
<i>If a man takes the birth control pill, he can make a girl pregnant.</i>	29.5	34.7	42.2	43.5
<i>A woman can become pregnant if she has sex standing up.</i>	43.9	43.8	63.2	51.8
<i>A girl can get pregnant even if she has sex only once.<sup>a</sup></i>	64.1	63.2	--	--
<i>Once a girl starts having monthly periods, it means she can get pregnant if she has sex.<sup>a</sup></i>	80.2	81.8	--	--

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Not included in adult questionnaire

In general, low levels of knowledge about pregnancy prevention were found, with adolescents consistently less knowledgeable than adults. For example, less than 30 percent of both adolescent and adult groups knew a woman could become pregnant even if she took two birth control pills just before

intercourse. Although adults were more likely to know the correct response than were adolescents, the majority still did not have correct information. On the question regarding male use of the birth control pill, fewer than half responded correctly. Close to 60 percent of adolescents and nearly 50 percent of adults did not know that a woman could become pregnant if she had intercourse standing up.

An additional statement was read to adolescents to explore the common belief that a girl cannot become pregnant if she has sex only once. Results suggest that nearly 40 percent did not know the correct answer. A question about puberty and the possibility of pregnancy was also included in the adolescent questionnaire. Results suggest that most young people understand that onset of menses signifies onset of fertility. Nearly 80 percent of adolescents answered this question correctly, leaving 20 percent with incorrect answers.

The low levels of knowledge found in this survey are especially significant. They suggest that while adults in Kenya are often expected to advise young people about sexuality they themselves are inadequately informed. When compounded with other factors deterring parent-child communication, such as shyness and awkwardness, lack of accurate information by adults only adds to the obstacles to communication with adolescents.

**Knowledge about specific family planning methods.** Knowledge of methods was assessed by asking the respondents to name the family planning methods they had heard about.<sup>8</sup> All methods mentioned spontaneously were checked off a list, and classified as spontaneous knowledge. If the respondent failed to name a method spontaneously, the interviewer described it and asked if the respondent recognized it. All methods recognized this way were classified as assisted knowledge. Nine modern methods—female sterilization, male sterilization, Norplant implants, injectables, the pill, intrauterine devices (IUDs), condoms, diaphragms, and foaming tablets—were described. In addition, three nonmodern methods—Natural Family Planning (NFP), withdrawal, and periodic abstinence were described. Other methods mentioned by the respondents such as breast feeding and traditional folk methods were recorded as nonmodern methods. For each method recognized, respondents were asked if they or their partners ever used it.

Results show that 73 percent of adolescent males and 67 percent of adolescent females could name a method of family planning spontaneously, and just under 90 percent of both genders could name a method after prompting (see Table 5.4). For adolescent males, the most commonly recognized method was condoms and for adolescent females, it was the pill. Norplant implants and the diaphragm were the least recognized methods among adolescents.

The majority of adults (almost 90 percent) could name any family planning method spontaneously; 97 percent of both males and females could after assistance. Like their adolescent counterparts, adult males cited the condom most, and adult females cited the pill most. Norplant implants and the diaphragm were also the least-recognized methods by adults.

<sup>8</sup> The specific question was: “Let us focus on child spacing or family planning methods. There are various ways that couples can use to delay or avoid pregnancy. Which methods have you heard of?”

Table 5.4

Percent Distribution of Respondents by Specific Contraceptive Methods Known,  
Kenya, 1994

Contraceptive Method	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
Any method (spontaneously)	73.2	66.6	90.1	88.1
Any method (after assistance)	87.6	85.7	97.2	96.5
Any modern method (spontaneously)	72.5	65.9	88.0	86.3
Any modern method (after assistance)	87.4	85.0	96.6	95.4
<b>Modern methods<sup>a</sup></b>				
Pill	71.2	77.6	90.3	92.7
Injectables	61.5	71.4	87.2	90.6
Condoms	82.8	72.5	92.3	83.9
IUD	35.8	53.4	70.5	76.9
Tubal ligation	47.7	57.7	78.3	81.3
Vasectomy	37.3	29.2	64.0	46.6
Foaming tablets	21.7	24.5	39.4	43.7
Diaphragm	18.0	19.5	34.9	27.6
Norplant implants	12.6	14.8	23.8	31.7
<b>Nonmodern methods<sup>a</sup></b>				
Natural Family Planning	44.2	53.1	76.3	68.3
Periodic abstinence	29.6	29.5	56.3	48.4
Withdrawal	23.8	24.0	55.7	41.0
Folk methods	15.7	14.5	32.0	27.2

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Includes spontaneous and assisted knowledge combined.

On average, adolescent females knew more methods than adolescent males—5.4 compared with 5.0. Adolescent males knew 3.9 modern methods and 1.1 nonmodern ones, while adolescent females knew 4.2 modern methods and 1.2 nonmodern ones. Adults knew more methods than adolescents and adult males knew more methods than adult females. Adult males knew an average of 8 methods—5.8 modern and 2.2 nonmodern. Adult females knew 7.6 methods—5.7 modern and 1.8 nonmodern.

**Interest in learning about contraception.** Over three-fourths of respondents in both age groups, especially males, expressed a desire to learn more about contraception. This suggests a receptive audience in more intense IEC activities for the future (see Figure 5.1).

### Attitudes Toward Family Planning

To assess family planning attitudes, respondents were asked if they agreed or disagreed with several statements about family planning. Possible responses were strongly agree, agree, disagree, strongly disagree, and don't know/no opinion. During analysis, responses were collapsed into agree, disagree, and don't know. Attitude statements were subdivided into three areas where family planning can benefit the family, the mother and child, and the couple.

**Benefits to the family.** Several questions were asked to assess the public perception about the benefits of family planning. In general, both adolescents and adults agreed that it is better to have fewer children (see Table 5.5, facing page). More than three-fourths of the study sample agreed that family planning would improve their standard of living and the majority felt that a couple that practices family planning had a happy family. There was general agreement that using contraception makes it easier to care for one's children.

**Benefits of family planning to mother and child.** The vast majority of adolescents and of adults agreed that family planning helps a mother regain strength after a pregnancy (see Table 5.5). Similar proportions

recognized that too many pregnancies are harmful to a woman's health and that spacing the number of births helps protect the health of mothers and their children. These beliefs were confirmed by other questions—when the statement, “Family planning is bad for your health” was read, only one-fourth of adolescent and adult males agreed; roughly one-third of adult and adolescent females agreed. This suggests, however, that while many respondents appreciate the importance of child spacing, a considerable number are concerned about the health effects of contraception.

**Benefits to the couple.** An important benefit of family planning can be its contribution to the emotional well-being of a couple by reducing the anxiety associated with unplanned pregnancy. When read the statement, “Couples that care for each other practice family planning,” over 60 percent of adolescents and nearly 80 percent of adults agreed. More adults also felt that with family planning, couples can love each other with peace of mind and the practice of family planning will bring a couple closer. Adolescents, especially males, were less likely to feel this way, perhaps because some adolescents were not involved in a relationship and could not ascertain the family planning benefits from that perspective. While nearly 80 percent of adults felt that a loving husband would allow his wife to use contraception, fewer adolescents agreed. For the most part, however, both groups agreed that a woman's beauty lasts longer if she has fewer children (see Table 5.5).

**Table 5.5 Percent Distribution of Adolescents and Adults Who Agree with Various Statements about Family Planning, Kenya, 1994**

Statement	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
<b>Benefits to the family</b>				
These days, having fewer children is better than having many.	87.9	91.3	93.1	93.9
The use of contraception makes it easier to care for children.	66.0	74.4	79.8	82.8
Family planning will improve one's standard of living.	79.9	80.9	87.0	86.8
<b>Benefits to the mother</b>				
Family planning will help a mother regain her health before the next pregnancy.	82.3	86.7	93.1	92.8
Too many pregnancies are bad for a woman's health.	79.9	84.4	86.9	87.3
Child spacing protects a mother's health.	83.1	90.3	93.0	95.6
Child spacing protects children's health.	81.2	87.9	92.0	94.2
Family planning is bad for your health.	23.9	35.7	25.0	31.0
<b>Benefits to the couple</b>				
Couples that care for one another use family planning.	65.5	69.1	82.1	78.3
With family planning, a couple can love each other with peace of mind.	66.1	71.2	80.1	76.8
The practice of family planning will bring a couple closer.	63.4	67.8	78.0	76.2
A husband who loves his wife allows her to use family planning.	66.3	71.2	80.6	78.2
A woman's beauty lasts longer if she has fewer children.	73.4	78.0	81.7	83.3
A couple that practices family planning has a happy family.	72.9	72.4	83.3	79.6

SOURCE:

NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

## Family Planning Practice

All respondents who knew of a particular method of family planning were asked if they or their current partner had ever used it. Percentages were calculated based on the total sample sizes (including those who have never heard of the method) to enable an assessment of overall contraceptive practice and to enable comparison with other studies. Roughly one-fourth of older adolescents had ever used a method (see Table 5.6). About 24 percent of adolescent males had used a modern method (mostly the condom) at least once, and 10 percent had used a nonmodern method (usually NFP). Adolescent females showed similar

patterns—15 percent had used a modern method (also mostly the condom) at least once, and 13 percent had used a nonmodern method, (also usually NFP).

**Table 5.6 Percent Distribution of Respondents Who Have Ever Used a Contraceptive Method <sup>a</sup> by Specific Method, Kenya, 1994**

Method	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
<b>Any method</b>	26.5	23.1	64.4	58.2
<b>Any modern method</b>	23.5	15.4	51.0	46.8
Pill	1.9	6.4	19.5	29.8
Injectables	1.2	2.1	8.5	18.3
Condom	21.4	9.6	35.7	8.5
IUD	1.3	0.8	5.3	8.5
Tubal ligation	0.0	0.0	3.3	5.9
Vasectomy	0.3	0.4	0.4	0.2
Foaming tablets	0.5	0.9	2.6	3.4
Diaphragm	0.3	0.5	1.6	1.6
Norplant implants	0.0	0.3	0.8	0.9
<b>Any nonmodern method</b>	10.2	13.3	35.7	25.4
Natural Family Planning	8.1	11.1	27.2	19.7
Periodic abstinence	2.6	4.4	15.7	10.0
Withdrawal	3.4	2.6	11.3	5.5
Folk methods	0.4	0.8	3.3	1.6

SOURCE:  
Survey (1994).

NCPD and JHU/CCP Kenya National IEC Situation

NOTE: <sup>a</sup>Use of the method by respondent or partner.

As expected, adults were more likely to use contraception—64 percent of men and 58 percent of women. Over half the men had used a modern method, usually the condom. About one-third had also used a nonmodern method, usually NFP. Among adult women, almost half had ever used a modern method, usually the pill. Like adult men, NFP was the most common nonmodern method cited by adult women.

**Trends in contraceptive use over the years.** In order to analyze the trends of contraceptive use over the past two decades, data for all women (married and unmarried) were compared with results from the 1977-1978 Kenya Fertility Survey (KFS), the 1984 Kenya Contraceptive Prevalence Survey (KCPS), the 1989 and 1993 KDHS's. Results showed that ever-use of any method has risen by over 20 percentage points in the past 15 years, from 29 percent in 1977-1978 to 49 percent in 1994 (see Table 5.8). This represents a 70-percent rise in "ever-use" of contraception during the period. Ever-use of a modern method more than tripled from 11 percent in 1977-1978 to 39 percent in 1994. There were no comparable data about overall ever-use of nonmodern methods before 1989. Data on NFP, however, show that its use rose from about 13 percent in 1977-1978 to 18 percent in 1994. Thus, much of the increase in contraception primarily was due to modern method use. There was also a gradual increase in ever-use of most methods, except for IUDs and NFP. The sharpest rise appears to have been in the ever-use of injectables, which rose from 2 percent in 1977-1978 to 14 percent in 1994.



**Table 5.7**  
**Percent of All Women <sup>a</sup> Ages 15 to 49 Who Have Ever Used Specific Family Planning**  
**Methods,**  
**Kenya, 1977-1978, 1984, 1989, 1993, and 1994**

Contraceptive Method <sup>b</sup>	1977-1978 KFS (N=8,100)	1984 KCPS (N=6,581)	1989 KDHS (N=7,150)	1993 KDHS (N=7,540)	1994 KNIECSS (N=2,217)
<b>Any method</b>	29.0	28.5	39.1	45.6	49.4
<b>Any modern method</b>	11.0	14.1	24.1	34.0	38.9
Pill	7.0	9.0	15.1	21.9	23.9
Injectables	2.0	2.0	5.5	10.8	14.3
Condom	3.0	2.0	3.6	6.8	8.8
IUD	2.0	4.0	6.8	7.2	6.6
Tubal ligation	1.0	2.0	3.8	3.9	4.4
Vasectomy	0.0	0.0	0.2	0.1	0.2
Norplant implant <sup>c</sup>	---	---	---	0.2	0.7
<b>Any nonmodern method</b>	---	---	21.9	19.8	22.4
Natural Family Planning <sup>d</sup>	13.0	13.0	19.4	17.0	17.5
Withdrawal	4.0	4.0	2.4	2.8	4.8

SOURCE: Kenya National IEC Situation Survey (1994). 1993 KDHS, (p.40); NCPD & JHU/CCP

NOTES: <sup>a</sup>All women, married and unmarried.

<sup>b</sup>Results for diaphragm, foam, and jelly not presented due to differences in wording between the surveys.

<sup>c</sup>No information on Norplant implants in 1977-1989 surveys. No information on nonmodern methods in 1977-1984 surveys.

<sup>d</sup>Natural Family Planning included counting days, rhythm, and safe period.

**Current use of contraception.** Respondents were asked, “Are you or your partner currently using a method or doing anything to prevent pregnancy?” Calculations are based on the entire sample, to enable an assessment of overall contraceptive use and to allow comparisons with the KDHSs. At the time of the interview, 15 percent of males ages 15 to 19 were using a method of contraception, compared with 14 percent of females the same age (see Table 5.8). The modern method of choice among both male and female adolescents was condoms. Contraception was higher among adults—42 percent of adult males and 36 percent of adult females were using a method of contraception at the time of the survey. The same proportions of men and women were using modern methods. Among men, the condom was the most commonly used method; among women, it was the pill.

**Table 5.8**  
**Percent Distribution of Respondents Currently Using Specific Family Planning**  
**Methods, Kenya, 1994**

Method	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
<b>Any method</b>	14.9	13.6	41.8	35.9
<b>Any modern method</b>	11.2	8.0	27.0	27.2
Pill	0.2	2.9	8.2	10.7
Injectables	0.2	1.2	3.8	7.8
Condom	10.3	4.2	12.6	1.8
IUD	0.4	0.0	1.9	3.1
Tubal ligation	0.0	0.0	3.3	5.9
Vasectomy	0.0	0.0	0.4	0.2
Foaming tablets	0.0	0.1	0.1	0.3
Diaphragm	0.0	0.0	0.1	0.3
<b>Any nonmodern method</b>	2.8	4.2	6.8	4.7
Natural Family Planning <sup>a</sup>	2.3	3.8	4.9	4.3
Periodic abstinence	0.3	0.1	1.8	1.1
Withdrawal	0.9	0.7	1.1	0.4
Folk methods	0.0	0.0	0.5	0.3

SOURCE: NCPD and JHU/CCP Kenya

National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Includes counting days, safe period, and rhythm methods.

The contraceptive trend for married women is presented on table 5.9. During the 1984 KCPS, 17 percent of married females were using some method of family planning (see Table 5.10). A decade later in 1994, that number more than doubled to 38 percent. The sharpest increase was in modern method use—in 1984, 10 percent of married women were using a modern method; in 1994, that number had almost tripled to 29 percent. At the same time, there was a decline in the use of nonmodern methods, from 7 percent in 1984 to 5 percent in 1994. While all modern methods registered gains, injectables showed the sharpest increase.

**Table 5.9**  
**Percent of Currently Married<sup>a</sup> Women Ages 15 to 49 Currently Using Specific**  
**Family Planning Methods, Kenya, 1984, 1989, 1993 and 1994**

Contraceptive Method	1984 KCPS (N=4,627)	1989 KDHS (N=4,765)	1993 KDHS (N=4,765)	1994 KNIECSS (N=1,187)
<b>Any method</b>	17.0	26.9	32.7	37.7
<b>Any modern method</b>	9.7	17.9	27.3	29.1
Pill	3.1	5.2	9.5	11.2
IUD	3.0	3.7	4.2	3.7
Injectables	0.5	3.3	7.2	8.2
Condom	0.3	0.5	0.8	1.5
Female sterilization	2.6	4.7	5.5	6.5
Male sterilization	0.0	0.0	0.0	0.2
<b>Any nonmodern method</b>	7.3	9.0	5.5	4.6
Natural Family Planning <sup>b</sup>	3.8	7.5	4.4 <sup>c</sup>	4.3
Withdrawal	0.6	0.2	0.4	0.4
Folk methods	2.9	1.3	0.6	0.4

SOURCE: 1993 KDHS, p.41 and NCPD &

JHU/CCP Kenya National IEC Situation Survey (1994).

NOTES: <sup>a</sup>Married includes those married and living together.

<sup>b</sup>Includes calendar, rhythm, and Natural Family Planning.

<sup>c</sup>In 1993, the description of NFP changed slightly from previous surveys.

**Table 5.10**  
**Percent Distribution of Current Modern Contraceptive Users, by Most Recent Source of Supply, Kenya, 1994**

Source of Supply	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=95)	Females (N=55)	Males (N=334)	Females (N=380)
Hospital/health post/family planning clinic	25.6	49.0	66.0	84.6
Shop/kiosk/market	31.9	11.6	10.7	0.3
Friends	19.8	10.7	5.9	1.3
Private doctor/nurse	2.2	2.8	4.7	4.3
Pharmacy/chemist	8.3	12.8	5.6	1.2
CBD agent/Outreach worker	8.7	0.0	4.2	7.6
At work/spouse's work	1.0	4.7	1.0	0.0
Don't know	1.3	6.8	1.0	0.0
Other	1.2	1.6	0.9	0.7
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

SOURCE:

NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

## Source of Family Planning Methods

Modern-method users were asked where they had obtained their most recent method. Among adolescent males, users were most likely to obtain them from shops, kiosks, or similar outlets. These results are consistent with recent focus group discussions among Kenyan adolescent males, most of whom obtained methods from commercial outlets, and "in the streets" (KYIP, 1995). Adolescent females were most likely to get their methods from hospitals or family planning clinics (see Table 5.11). Adults were more likely to use family planning clinics and hospitals than adolescents. Two-thirds of adult men said that they (or their partners) obtained their most recent method from a hospital or family planning clinic and only 11 percent obtained them from shops. Among adult women, 85 percent of current users obtained their method from the hospital or family planning clinic.

**Table 5.11**  
**Percent Distribution of Respondents by the Terms They Used to Refer to CBD Agents, Kenya, 1994**

Term for CBD Agent	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=164)	Females (N=148)	Males (N=421)	Females (N=478)
Family planning worker	28.8	41.6	47.5	38.4
Don't know	13.3	17.7	31.2	39.5
Health worker	24.2	10.7	14.5	14.9
Other <sup>a</sup>	20.2	19.3	0.1	0.1
Doctor	12.6	6.1	0.0	0.0
World vision worker	0.0	0.0	3.8	2.8
No special name	0.0	0.0	2.3	3.9
Social worker	1.0	4.8	0.0	0.0
Action aid	0.0	0.0	0.7	0.4

SOURCE:

NCPD and JHU/CCP Kenya

National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Includes City Commission, Maendeleo, and other NGO-based CBD workers. A large adolescent response, interpret with caution.

This apparent transition from commercial outlets to medical facilities may reflect contraceptive patterns as one moves from adolescence to adulthood. Adolescent users usually rely on nonprescriptive methods such as condoms and nonmodern methods, while adults may use prescriptive methods such as pills. Adolescents may be reluctant to visit family planning clinics because of anxiety about how they will be treated, awkwardness when waiting for services with older women, and other barriers associated with low access to family planning services for young people. Commercial outlets provide the anonymity young people desire, and they may choose these outlets in spite of their greater expense compared with public facilities. This limited access to contraceptives for young people forces them to use less reliable methods, to buy methods where they can, and could even contribute to their decision not to use. This leaves adolescents at an unfair disadvantage compared to adults. Efforts should be made to alleviate these problems and to provide free and accessible services to young people who need them.

## Community-based Distribution

### Agents

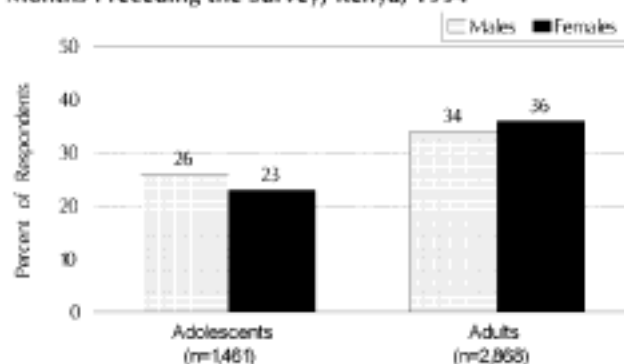
Community-based distribution (CBD) agents are an important part of the Kenya family planning program supply system. CBD agents provide men and women in their catchment areas with information, motivation, and, in some cases, nonprescriptive family planning methods. They operate under the auspices of governmental and nongovernmental organizations and are usually provided with training, supplies, and sometimes a stipend.

**Awareness of community-based providers.** To assess the coverage of the CBD program, respondents were asked if they were aware of CBD agents by briefly describing what an agent does and asking if the respondent had seen such persons in the area in the past three months. The results indicate that 34 percent of adult males and 36 percent of adult females knew of a CBD worker in their area. Adolescents were less likely than adults to be aware of CBD agents (see Figure 5.2). This suggests that CBD agents are geared more toward adults than adolescents. Respondents aware of CBD agents were also asked for general terms used to refer to these workers. Data showed that CBD agents are known by various terms depending on the region in which they operate (see table 5.11); their most common name is “family planning workers.” Some respondents—40 percent of adult females—did not know what CBD agents are called. Programs attempting to assess the coverage of CBD agents may, therefore, need to use detailed verbal descriptions in order to increase accuracy of assessment.

**Contact with community-based agents.** Respondents who were aware of CBD agents were asked if they had been visited by an agent in the past year, and 58 percent of adult males and 60 percent of adult females said they had. About 42 percent of adolescent males and 38 percent of adolescent females also reported visits. To estimate CBD coverage more fully, data also included those who were not aware of CBD agents. The results reveal that 19 percent of adult males and 22 percent of adult females had been visited by a CBD agent (see Table 5.12).

Another approach to estimate contact with CBD agents was used. All women of reproductive age (15 to

Figure 5.2.  
Respondents Who Have Seen a CBD Agent in the Three Months Preceding the Survey, Kenya, 1994



SOURCE: NORD and HURICOP National EC Situation Survey 1994b.

49) were asked if they were aware of CBD agents and if they had contact with one in the year before the survey. This analysis revealed that 33 percent of women ages 15 to 49 had seen a CBD agent in the neighborhood, and 18 percent had a visit from an agent. The fact that only one-third of reproductive age women had actually seen a CBD agent in a whole year points to the scarcity of these valuable service providers. Efforts should be made to increase the number of CBD agents since current numbers are not able to reach the target population.

**Table 5.12**  
**Percent Distribution of Respondents Who Reported a CBD Agent Visit in the Past Year**  
**Kenya, 1994**

Reported CBD Visit	Adolescents 15 to 19		Adults 20 to 54	
	Males	Females	Males	Females
<b>Among those aware of CBDs</b>				
Yes	41.6	38.1	57.5	60.0
No	58.4	61.9	42.5	40.0
TOTAL	100.0	100.0	100.0	100.0
Number of respondents	(173)	(160)	(429)	(494)
<b>Among all respondents</b>				
Yes	10.3	8.4	18.7	21.5
No	89.7	91.6	81.3	78.5
TOTAL	100.0	100.0	100.0	100.0
Number of respondents	(730)	(739)	(1,407)	(1,465)

SOURCE:

Situation Survey (1994).

NCPD and JHU/CCP Kenya National IEC

## Reasons for Not Using Family Planning Methods

All nonusers of contraception were asked to state their primary reason for nonuse. Analysis included only married adults or sexually active adolescents to exclude those respondents who did not have an obvious need for contraceptives. Among adolescent males and females, the main reasons given by nonusers were that they were not married, "no reason," not currently sexually active, lack of knowledge, and wants children. Very few adolescents cited cost, religion, partner opposition, or inconvenience of methods (see Table 5.13).

The main reasons cited by adult males was desire for children, "no reason," not married, and spouse/partner recently delivered or currently pregnant. Among adult females, desire for children also was the most cited reason for nonuse, followed by having recently delivered or being currently pregnant, "no reason," and fear of side effects. Like the adolescents in the study, very few adults cited cost, religion, partner opposition or inconvenience of methods as a deterrent to contraception.

## Intention to Use Family Planning in the Future

All nonusers (regardless of sexual activity or marital status) were asked if they intended to use family planning in the near future. Results show that most intend to use, an indication of possible increased demand in the future (see Figure 5.3). Roughly 63 percent of adolescent males and 71 percent of adolescent females said they intend to use contraception in the future. By comparison, 67 percent of adult males and 59 percent of adult females intend to do so.

**Table 5.13**  
**Percent Distribution of Married or Sexually Active<sup>a</sup> Respondents Who Were Not Using a Contraceptive Method, by Primary Reason for Not Using, Kenya, 1994**

Reason for Not Using Contraception	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=298)	Females (N=210)	Males (N=551)	Females (N=629)
Not married	48.8	19.6	9.3	1.9
Wants children	1.5	12.6	31.3	22.7
No reason	25.0	16.4	14.6	12.9
Now pregnant/just delivered/breastfeeding	1.3	9.1	7.2	13.7
Not currently sexually active	5.7	7.0	3.9	1.2
Side effects/health reasons	1.1	9.9	5.5	11.1
Infertile/menopausal	0.7	0.0	4.0	9.0
Personally opposed to family planning	0.8	1.9	3.7	5.2
Lacks knowledge	3.7	10.6	5.3	4.7
Religion	1.0	0.9	2.8	2.7
Hard to get methods	2.0	0.0	2.5	1.0
Costs too much	1.5	0.9	0.2	0.3
Partner opposed	0.0	2.5	1.2	4.9
Methods inconvenient	0.3	1.7	2.0	2.1
Other reasons <sup>b</sup>	6.6	6.9	6.5	6.6
<b>Total</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>	<b>100.0</b>

SOURCE:

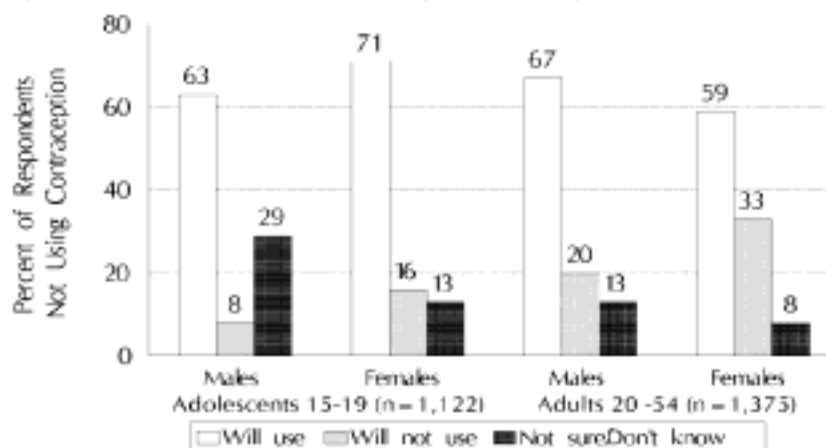
NCPD and JHU/CCP Kenya National IEC

Situation Survey (1994).

NOTES: <sup>a</sup> Ever had sex.

<sup>b</sup> Includes does not where to get methods, fatalistic, opposition from others, etc.

**Figure 5.3.**  
**Percent Distribution of Respondents Not Using Contraception, by Intention to Use Contraception, Kenya, 1994**



SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).



## Chapter VI. Interpersonal Communication and Social Support

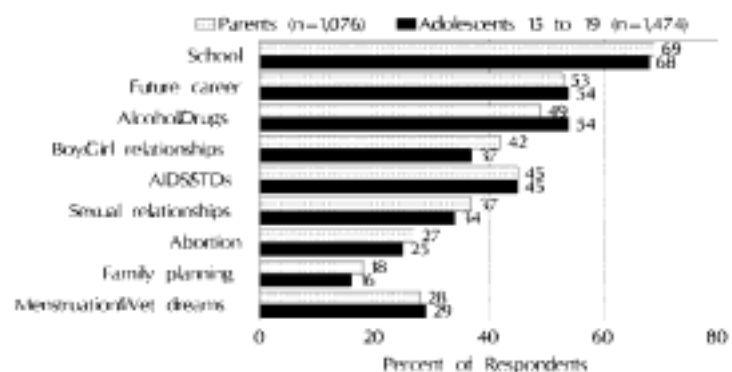
To assess interpersonal communication, respondents were asked how often they talked with others about a variety of topics including finances, future careers, family planning, fertility preferences, and sexuality. These questions would help ascertain the extent families and the community discuss these issues, and whether they agree or disagree with each other. Parents were also asked how often they talked to their children about selected topics, and the children were asked how often they talked to their parents about these same topics. The assessment focused particularly on parent-child communication and its frequency. Free intergenerational and intragenerational communication may indicate the level of support respondents feel when making reproductive health decisions.

### Communication Between Parents and Children

Parents were asked if they had children between the ages of 10 and 19 living at home. Those who did were asked about communication with their oldest child in that age group. The parents were asked whether they had spoken to their child about selected topics in the year preceding the survey. The child was also asked if one of the parents had talked to him/her about these same topics in the same time period (see Figure 6.1). Findings show remarkable agreement between the adolescents and their parents. Both parents and young people were most likely to report having discussed school, future careers, and alcohol/drug use. Less than half the parents or the young people reported a discussion about boy/girl relationships, AIDS/STDs, or sexual relations. Less than one-third had discussed abortion, contraception, or puberty.

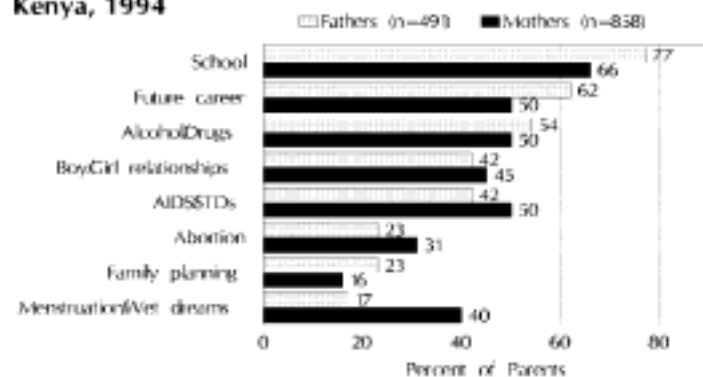
Results showed some gender differentials. Fathers were more likely than mothers to have discussed school matters, future careers, and alcohol and drugs to their children. Mothers were more likely than fathers to have discussed reproductive health issues such as boy-girl relationships, AIDS/STDs, abortion, and puberty. Interestingly, however, slightly more fathers talked to their children about family planning than mothers (see Figure 6.2).

**Figure 6.1.**  
Parents and Adolescents Who Reported Speaking to Each Other about Selected Topics in the Past Year, Kenya, 1994



SOURCE: NCPD and JHUA/CCP Kenya National IEC Situation Survey (1994).

**Figure 6.2.**  
Parents of Adolescents Ages 15-19 Who Reported Speaking to Their Children about Selected Topics in the Past Year, Kenya, 1994



SOURCE: NCPD and JHUA/CCP Kenya National IEC Situation Survey (1994).



Analysis compared the issues mothers and fathers discussed with their sons to the issues discussed with their daughters (see Figure 6.3 for mothers and Figure 6.4 for fathers).

Mothers reported talking to both their sons and daughters equally about future careers; fathers reported talking more to their sons than their daughters about future careers. Both parents were more likely to talk to sons than to daughters about alcohol and drug use. Mothers reported talking more to their daughters and fathers to their sons about AIDS/STDs, boy/girl relationships, sexual behavior, family planning, abortion, and puberty. Thus, parents appear to split roles along gender lines with respect to reproductive health discussions. Still, the majority of parents had not discussed reproductive health in the preceding year and when it was discussed, girls were more likely to report it than boys. This suggests that interventions to help parents discuss reproductive health with their children may be needed.

## Communication about Sexuality among Adolescents

Adolescents ages 15 to 19 were asked how comfortable they would feel talking about sexual matters to a number of individuals such as their mother, father, brother, or sister (see Figure 6.5). Possible answers were “very comfortable,” “comfortable,” and “uncomfortable.” Results show that young males were most uncomfortable talking to their mothers, aunts, fathers, sisters, uncles, and members of the clergy, in that order. Adolescent males appeared most comfortable talking to their brothers, friends, and health care workers. The results among adolescent females mirrored the adolescent males—females appeared most uncomfortable talking with their fathers, uncles, brothers, and members of the clergy. They appeared most comfortable talking to a sister, friend, boyfriend, or health care workers.

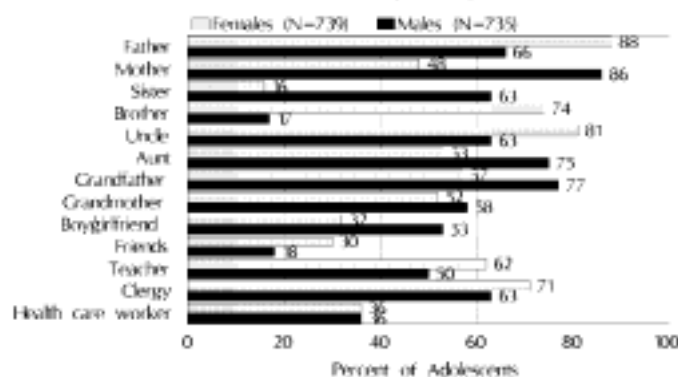
**Figure 6.3.**  
Mothers Who Discussed Selected Topics with Sons and Daughters in the Past Year, Kenya, 1994



**Figure 6.4.**  
Percent of Fathers Who Discussed Selected Topics with Sons and Daughters in the Past Year, Kenya, 1994



**Figure 6.5.**  
Adolescents Ages 15 to 19 Who Feel Uncomfortable Talking to Selected Individuals about Sexuality, Kenya, 1994



SOURCE: NCPD and JHUPCS Kenya National IEC Situation Survey (1994).

## Communication Between Husband and Wife

The level of communication that a couple has regarding day-to-day issues can have a bearing on how comfortable they are in discussing sensitive topics such as family planning. Respondents were asked how often they had talked to their spouses about five topics—religion, children’s education, future plans, finances, and family planning—in the preceding year. Possible answers were “never,” “once or twice,” and “more often.” Analysis was limited to married adults ages 20 and older because of the small proportions of adolescents ages 15 to 19 who were married. Among both men and women, the most frequently discussed topic was finances and men were more likely to report these discussions than women. Children’s education and future plans were also frequently discussed by both genders, although females were less likely to report such a discussion than males. Of the topics presented, family planning was the topic least likely to have been discussed. For example, 27 percent of men and 34 percent of women said they had not discussed family planning that year (see Table 6.1). Of interest is the finding that adolescents remain somewhat apprehensive about talking to grandparents. Over half are uncomfortable talking to either grandparent about sexual matters.

**Table 6.1**

**Percent Distribution of Married Adult Respondents,<sup>a</sup> by Whether They Talked to Their Spouses about Specific Issues in the Past Year, Kenya 1994**

Issues	Men			Women			Number of respondents		
	Never	Once or twice	More often	Never	Once or twice	More often	Males	Females	Total
Finances	4.3	13.0	82.6	9.2	22.2	68.6	(1,048)	(1,153)	100.0
Future plans	5.2	15.8	79.9	11.0	22.3	66.6	(1,049)	(1,152)	100.0
Children’s education	9.6	14.9	75.5	13.1	20.1	66.8	( 999)	(1,100)	100.0
Religion	11.1	20.0	68.8	13.7	26.4	59.9	(1,050)	(1,151)	100.0
Family planning	26.8	20.1	53.1	33.7	25.7	40.6	(1,059)	(1,171)	100.0

SOURCE:

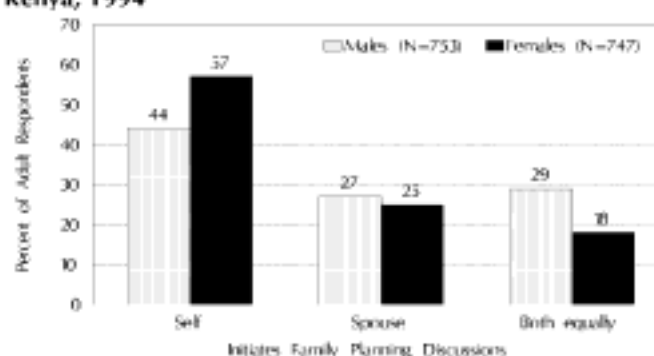
NCPD and JHU/CCP Kenya National IEC Situation

Survey (1994).

NOTE: <sup>a</sup> Marriage was defined based on respondents answer to the question, “What is your marital status?” Only those who said “married” are included in this analysis.

Respondents who had discussed family planning with their spouse in the preceding year were asked who usually started the discussion—the respondent, the spouse, or both. Analysis was again limited to married adults aged 20 and above. Results suggest that females (51 percent) were more likely to say they initiated the discussion, although nearly half the males report initiating the discussion (see Figure 6.6). When asked to assess whether these discussions were generally for or against family planning 89 percent of men and 80 percent of women who had discussed the topic said that the talks were generally favorable. About 4 percent of men and 9 percent of women found them unfavorable, and the remainder (7 percent of men and 11 percent of women) found them “neutral.”

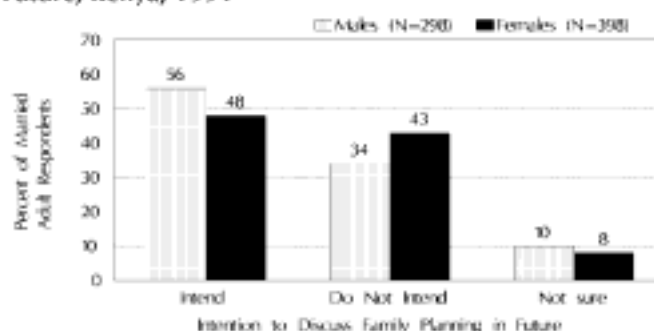
**Figure 6.6.**  
**Married Adult Respondents Who Have Discussed Family Planning by Who Initiates Family Planning Discussions, Kenya, 1994**



SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

Many of those who had discussed contraception with their spouses found it easy to talk to them. For example, 96 percent of husbands found it easy to talk to their wives, 84 percent of wives found it easy to talk to their husbands. Roughly 4 percent of men and 15 percent of women found it difficult to talk to their spouses about family planning. Those who had never talked to their spouses were asked if they had ever wanted to do so but felt inhibited for some reason. The same proportions—34 percent of men and 34 percent of women—said they have wanted to discuss it. The remaining two-thirds had not wanted to discuss family planning. When all (i.e., those who had not discussed family planning with their spouse) were asked if they intended to talk to them in the near future, more men than women said they would, while roughly 10 percent of each gender were not sure (see Figure 6.7).

**Figure 6.7.**  
Married Adult Respondents Who Had Not Talked to Their Spouses about Family Planning, by Intention to Discuss in the Future, Kenya, 1994



SOURCE: NCPD and JHU/PCF Kenya National IEC Situation Survey (1994).

## Communication with Others about Family Planning

Respondents, including adolescents ages 15 to 19, were asked if they had talked to various individuals about family planning in the preceding year. A list of individuals was read, and the respondent could answer “yes” or “no.” For both adolescent males and females: friends, teachers, relatives, and spouses (if married) were an important contact for family planning discussions (see Table 6.2). The communication patterns of adult males and females were also similar to each other; each gender most likely spoke to their spouse or a friend. The third most common person adult females spoke to were health care workers, while adult males spoke to other relatives.

**Table 6.2**  
Percent Distribution of Respondents Who Talked to Selected Individuals about Family Planning in the Past Year, Kenya, 1994

Individual	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
Spouse <sup>a</sup>	(23.3)	43.4	70.1	56.2
Parents	17.2	18.5	12.8	13.0
Other relatives	24.0	28.7	36.4	35.9
Son (if have)	-	-	10.9	7.7
Daughter (if have)	-	-	13.0	12.6
Friends	47.8	39.6	47.4	47.2
Health care worker	12.4	18.7	30.8	39.4
Clergy	17.2	16.3	26.4	27.0
Community leader	9.2	8.4	25.8	20.8
School teacher	38.0	27.8	18.8	13.5

SOURCE:

National IEC Situation Survey (1994).

NOTES: <sup>a</sup> Among those who are married.

( ) Fewer than 20 observations in denominator, interpret with caution.

NCPD and JHU/PCS: Kenya

## Opinion of Others about Family Planning

Respondents were asked how important the opinions of selected individuals were to the respondent on the use of family planning. Possible answers were “not important,” “somewhat important,” “very important,” and “don’t know.” Results suggest that school teachers are the individuals whose opinion most adolescent males consider most important, followed by spouse (if married), friends, and parents. For adolescent females, the spouse is the person whose opinion most consider important, followed by school teachers, friends, and parents. The pattern for adults suggests that, among males and females, the largest proportion of respondents cite their spouse as the person whose opinion they consider as “most important,” followed by health care workers and friends, in that order (see Table 6.3).

**Table 6.3**  
**Percent Distribution of Respondents by Perceived Level of Importance of Selected Individuals’ Opinions about Family Planning Use, Kenya, 1994**

Individual	Level of Importance to Adolescents 15 to 19				Level of Importance to Adults 20 to 54			
	Not	Somewhat	Very	Don’t know	Not	Somewhat	Very	Don’t know
<b>Spouse<sup>a</sup></b>								
Males	(0.0)	(39.1)	(43.3)	(17.6)	2.6	14.1	76.4	7.0
Females	8.3	9.0	64.3	18.4	7.9	14.3	67.7	10.1
<b>Parents</b>								
Males	8.5	21.3	41.4	28.7	8.7	23.2	32.2	36.0
Females	9.5	21.9	40.8	27.9	18.5	22.2	24.1	35.2
<b>Other relatives</b>								
Males	6.9	30.6	35.8	26.7	6.5	34.8	32.6	26.1
Females	8.3	31.0	34.1	26.6	13.3	33.5	27.6	25.5
<b>Son</b>								
Males	-	-	-	-	12.6	19.7	27.3	40.5
Females	-	-	-	-	19.5	13.9	15.9	50.8
<b>Daughter</b>								
Males	-	-	-	-	12.7	14.2	33.1	40.1
Females	-	-	-	-	16.3	13.7	26.7	43.3
<b>Friends</b>								
Males	9.0	30.1	42.2	18.7	7.0	34.4	39.1	19.5
Females	11.8	24.4	41.4	22.5	11.9	34.0	37.1	17.1
<b>Religious leader</b>								
Males	10.4	20.8	34.5	34.3	8.6	22.3	35.0	34.2
Females	14.3	15.7	27.5	42.6	13.8	23.8	33.6	28.7
<b>Health care worker</b>								
Males	8.9	18.7	33.9	38.6	6.4	18.2	44.9	30.6
Females	10.4	18.2	34.6	36.8	11.3	20.5	47.7	20.5
<b>Community leader</b>								
Males	11.1	21.8	25.8	41.3	6.4	24.1	35.5	34.0
Females	16.2	15.9	17.1	50.8	12.9	22.1	30.2	34.9
<b>School teacher</b>								
Males	8.3	22.1	48.3	21.3	8.1	18.1	33.9	40.0
Females	10.8	17.2	43.0	29.0	14.6	21.4	22.6	41.4

SOURCE:  
Survey (1994).

NCPD and JHU/CCP Kenya National Situation

NOTES: <sup>a</sup> Among those who are married;  
( ) Less than 20 respondents in denominator, interpret with caution.

A comparison of adults’ and adolescents’ results yields interesting findings. The prominence of school teachers as a source of opinions among adolescents suggests that young people greatly value the information they get from teachers. Enhancing this channel of communication may be an important

component of an adolescent communication program. Likewise, the lower rank of parents among adolescents may be a reflection of the lesser role they appear to play in discussing reproductive health with their children. The prominence of health care workers as a source of opinions among adults compared with adolescents may reflect access—adolescents may have less access to health care workers, therefore, making health care workers less influential among young people. Data also suggest that adolescents consider the views of many individuals as equally important, while adults appear to consider their spouse as most important and others less so. For example, while adolescent males consider the opinions of spouses, friends, and parents as equally important, adult males consider the opinion of their wives most important by a wider margin than any of the other individuals listed. A similar pattern is observed between adolescent females and adult females.

### **Perceived Support for Family Planning**

Respondents were asked whether they thought the individuals in their social network (listed in Table 6.3) would approve if they were using family planning. Among adolescents, friends, followed by other relatives (males) and spouses (females), were the most likely to be thought of as approving the respondent's use of family planning. Among adults, spouses, followed by friends (among males) and health care workers (among females), were the most likely to be seen as approving (see Table 6.4).

**Table 6.4**  
**Percent of Respondents Who Believe Selected Individuals Would Approve or Disapprove of Respondent's Use of Family Planning, Kenya, 1994**

Individual	Belief of Adolescents			Belief of Adults		
	Approve	Disapprove	Don't know	Approve	Disapprove	Don't know
<b>Spouse<sup>a</sup></b>						
Males	19.0	8.6	72.4	78.7	8.2	13.1
Females	45.9	21.3	32.8	65.4	14.9	19.7
<b>Parents</b>						
Males	38.0	19.2	42.8	33.9	20.4	45.8
Females	27.7	29.2	43.0	30.0	22.4	47.5
<b>Other relatives</b>						
Males	41.0	13.5	45.5	43.1	10.6	46.3
Females	30.0	24.2	45.8	39.9	14.0	46.2
<b>Son</b>						
Males	-	-	-	22.4	11.0	66.6
Females	-	-	-	12.8	12.4	74.8
<b>Daughter</b>						
Males	-	-	-	25.4	8.6	66.0
Females	-	-	-	22.2	10.9	66.9
<b>Friends</b>						
Males	50.7	13.0	36.3	54.8	9.8	35.4
Females	48.0	15.3	36.7	57.4	9.5	33.1
<b>Religious leader</b>						
Males	25.0	13.0	61.9	52.0	8.6	39.4
Females	35.6	13.3	51.2	48.8	10.2	41.1
<b>Health care worker</b>						
Males	37.2	10.1	52.7	54.2	5.5	40.3
Females	38.6	12.9	48.5	58.6	8.2	33.2
<b>Community leader</b>						
Males	27.4	17.1	55.5	40.9	11.6	47.5
Females	24.3	20.8	54.9	35.9	16.7	47.5
<b>School teacher</b>						
Males	28.7	12.5	58.8	45.0	6.8	48.3
Females	22.3	16.0	61.7	35.5	12.5	52.0

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Among those who are married.

Adolescents: n=735 (males), n=739 (females)

Adults: n=1417 (males), n=1476 (females)

Although the opinion of teachers regarding family planning was seen as one of the most important for adolescent males, 59 percent of adolescent males were not as certain of their teacher's support. A notable proportion of respondents valued their spouses' opinions and these individuals were most likely to support the respondent's use of family planning. Similarly, the views of health workers were considered important by adults, and health workers were also likely to support the respondent's use of contraception.

Many respondents did not know whether some of the individuals listed would approve or disapprove of the respondent's use of family planning, and such a response can be expected in some cases (e.g., many respondents did not know the opinion of their sons, daughters, religious leaders, etc.). However, many people did not know the stance of their spouses. For example, as many as one-third of married adolescent females and one-fifth of their adult counterparts did not know whether their spouses would approve if they were using contraception, suggesting an appreciable lack of communication.

## Decision-making within the Family

Respondents were asked who should make the decision to use family planning and also who makes the decisions in the household. Because the answers anticipated an independent household, adolescents and unmarried respondents were excluded from this analysis. Respondents were fairly split on the issue—most men said both husband and wife should make the decision to use family planning (45 percent), while most women said the wife should (37 percent). About 42 percent of men said that the husband should make the family planning decisions and 25 percent of women agreed (see Table 6.5).

When asked who makes most of the general decisions in the family, 71 percent of men said they did and 57 percent of women said their husbands did (see Table 6.5). About 25 percent of men and 27 percent of women said that the couple jointly made the general family decisions. The wife was only involved, either jointly with her husband or independently, in making general decisions for the family in less than half the cases. By comparison, husbands are involved in the decision-making either independently or jointly, in 95 percent of the cases.

**Table 6.5**  
**Percent Distribution of Married Adult Respondents, by Who**  
**They Think Should Make Family Planning and General**  
**Decisions, Kenya, 1994**

Decision-maker	Males	Females
<b>To use family planning</b>		
Husband	41.9	25.0
Wife	9.1	37.4
Together	45.3	32.6
Either	1.8	1.2
Neither	0.2	1.0
Don't know	1.7	2.8
TOTAL	100.0	100.0
Number of respondents	(1,053)	(1,163)
<b>General decisions</b>		
Self	71.1	14.2
Together	24.1	27.0
Husband	---	57.3
Wife	3.7	---
Parents/In-laws	1.1	1.5
TOTAL	100.0	100.0
Number of respondents	(933)	(1,128)

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994)

## Chapter VII. Awareness and Attitudes about HIV/AIDS

HIV/AIDS prevalence in Kenya has risen sharply in the last few years, and is expected to become Kenya's most serious health problem in the next decade. Data suggest seroprevalence of 8 percent nationwide and nearly 4 percent in rural areas. About 66,000 cases of HIV/AIDS have been reported to the Ministry of Health since the epidemic began through June, 1996 (MOH & NCPD, 1996). Young women in the age group 14-24 are almost twice as likely to be infected as males in the same age group. It is estimated that by the year 2000, about half of the hospital beds in Kenya will be required for HIV/AIDS patients (MOH & NCPD, 1996). The Government of Kenya has begun major efforts to respond to the HIV/AIDS crisis including establishing a number of high level agencies to implement activities in the country. Public education and prevention campaigns in collaboration with international, national, and local NGOs have also been initiated by the government.

The KNIECSS provided an opportunity to examine how successful these efforts have been and how informed the public is about HIV/AIDS. The survey aimed to determine respondents' understanding of the various ways through which HIV/AIDS can be transmitted, most susceptible persons, methods of personal prevention, whether condoms can prevent HIV/AIDS transmission, sources of information about HIV/AIDS, and personal relationships with family members who could be victims of HIV/AIDS. Because of the sensitivity of the topic, these questions were limited to respondents ages 15 and older.

### Perceived Methods of HIV/AIDS Transmission

Virtually all respondents reported that they had heard of HIV/AIDS. Among older adolescents, 98 percent of males and 97 percent of females had heard of HIV/AIDS compared with 99 percent of both adult males and females. All respondents who had heard of HIV/AIDS were asked how the disease was transmitted, and their answers were checked off against a list of commonly cited modes. For each mode not spontaneously mentioned, the interviewer read it aloud and asked whether HIV/AIDS could be transmitted in that manner. The results are presented on Table 7.1 and show that while people are aware of HIV/AIDS, knowledge of its transmission is largely superficial.

**Table 7.1**  
**Percent Distribution of Respondents' Cited Method of HIV/AIDS Transmission**  
**Kenya, 1994**

Method of HIV/AIDS Transmission <sup>a</sup>	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,478)
Having sex with infected person	93.7	89.7	95.0	94.8
Transfusion with infected blood	79.6	78.9	84.3	84.5
Contaminated instruments	78.3	74.6	79.4	80.9
Having sex with a prostitute	76.2	62.0	78.2	67.1
Mother to child	56.8	61.9	59.8	67.0
Insect bites	32.1	33.3	27.7	33.2
Kissing	20.8	19.4	20.8	26.0
Used clothing	18.1	18.3	19.1	23.4
Sharing cups, forks, etc.	17.1	21.2	17.6	24.8
Traveling outside Kenya	13.2	9.6	10.7	15.1
Witchcraft	11.3	11.5	11.3	10.6
Shaking hands	10.5	18.0	16.2	16.9
Act of God	5.6	5.5	5.9	7.4

SOURCE:  
Survey (1994).

NCPD and JHU/CCP Kenya National IEC Situation

NOTE: <sup>a</sup> Includes both assisted and spontaneous knowledge





Although the majority did cite correct methods of HIV/AIDS transmission, there were small proportions who did not recognize the correct methods. For example, while more than 90 percent of adults and male adolescents knew HIV/AIDS could be transmitted sexually, nearly 10 percent of adolescent females did not think so. Roughly 80 percent to 85 percent of respondents believed that a transfusion with infected blood could be a means of HIV-transmission. The remaining 15 percent to 20 percent of the respondents did not appear to know this information about transmission and their lack of knowledge could render them vulnerable to these modes of transmission. One-third of female respondents and around one-fifth of their male counterparts did not know that having sex with a prostitute could lead to HIV/AIDS, and even greater numbers did not know that HIV/AIDS can be transmitted from mother to child.

A large number of misconceptions about the disease also exist. For example, about one-third of the respondents believed that one could get HIV/AIDS from insect bites, wearing used clothing, and sharing cups, forks, and cooking utensils. Anywhere from 10 percent to 20 percent believed one could get HIV/AIDS by shaking hands, traveling outside Kenya, or being bewitched. Smaller numbers believed that HIV/AIDS was an act of God.

## Condoms and HIV/AIDS

Respondents were asked whether they thought condoms could protect against HIV/AIDS. Nearly three-fourths of males and nearly 60 percent of females felt condoms could indeed protect against the disease (see Figure 7.1). This means, however, that 30 percent of men and 42 percent of women do not believe condoms offer any protection against HIV/AIDS. While condoms can protect only if used correctly, and while there are other modes of HIV/AIDS transmission besides sexual modes, this lack of faith reduces the likelihood that condoms will be used. The main reason reported by individuals skeptical about the protective ability of condoms is that condoms can burst or tear.

About 20 percent felt condoms had holes, 13 percent to 20 percent felt one could get HIV/AIDS other ways, and a small proportion said it is difficult to use them all the time (see Table 7.2).

**Figure 7.1.**  
Respondents Who Believe Condoms Protect Against HIV/AIDS, Kenya, 1994



SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).  
NOTES: \* Adolescents (N=733); Females (N=743).  
\*\* Males (N=1,416); Females (N=1,476).

**Table 7.2**  
Percent Distribution of Respondents Who Believe Condoms Are Not Effective Against HIV/AIDS Transmission, by Reason, Kenya, 1994

Reason	Adolescents 15 to 19		Adults 20 to 34	
	Males (N=184)	Females (N=278)	Males (N=444)	Females (N=563)
Condoms can burst or tear	44.6	38.9	61.3	44.4
Some condoms have holes	20.8	23.1	22.2	22.2
Can get HIV/AIDS other ways	13.5	14.0	20.3	15.3
Difficult to use all the time	1.9	3.7	2.8	1.6

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

## Interpersonal Communication about HIV/AIDS

About 44 percent of male adolescents and 37 percent of their female counterparts said they had talked to

someone about HIV/AIDS in the three months before the survey. By comparison, 55 percent of adult males and 52 percent of adult females had done so as well. Thus, females were less likely to have discussed HIV/AIDS with anyone when compared with males, and adolescents were less likely to have discussed it when compared with adults. Those who had talked to someone were read a list and asked if they had talked to the specified individual. Among both adults and adolescents, friends were the person a respondent would most likely talk to, followed by spouses/partners and relatives (see Table 7.3).

**Table 7.3**  
**Percent Distribution of Respondents Who Talked to Someone about HIV/AIDS in Past Three Months,**  
**by Individual Talked to, Kenya, 1994**

Individual	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=314)	Females (N=265)	Males (N=735)	Females (N=596)
Friends	87.1	80.7	87.9	80.1
Spouse/partner <sup>a</sup>	45.4	54.3	61.2	57.5
Relatives	33.9	43.4	37.1	43.7
Neighbor	10.2	17.0	17.2	22.1
Health Workers <sup>b</sup>	6.4	9.1	12.3	17.5
Co-workers	5.7	3.1	21.9	13.9

SOURCE:

Situation Survey (1994).

NCPD and JHU/CCP Kenya National IEC

NOTES: <sup>a</sup> Among those who are married, or have a boyfriend, or girlfriend.

<sup>b</sup> Includes nurse, midwives, doctors, chemists/pharmacists, and other health personnel.

## Source of Information about HIV/AIDS

The majority of respondents received most of their information about HIV/AIDS on the radio, underscoring the importance of this medium for both adults and adolescents. Fully 80 percent of adult men and 68 percent of adolescent boys cited this as their main source of information about HIV/AIDS (see Table 7.4). Radio was the number one source of information for adolescent and adult women as well. Friends were the second most cited source of information for males and females, regardless of age. For adolescents, school was the third most important source, pointing out the dependence that young people place on what they learn in school. For adults, the third most important source was newspapers for men and health workers for women. Thus, these five sources—radio, friends, schools, newspapers, and health workers—provided most of the HIV/AIDS information for the majority of the audience.

## Reaction to a Relative with HIV/AIDS

To gauge people's beliefs and fears about HIV/AIDS, respondents were asked to imagine that they had a relative who had HIV/AIDS. Several actions they could take toward him/her were read to them and they were asked how they would respond. The actions included speaking in public, visiting room, shaking hands, using same plates, wearing same clothes, allowing children to play with him/her, and taking care of him/her when ill. Possible answers were "definitely," "maybe," "not at all," or "do not know."

Results suggest that the majority of respondents would speak to such a relative in public, with adults more likely to do so than adolescents (see Table 7.5). Nearly one-third of adolescent males and females, and one-fifth of their adult counterparts, however, said they would not speak to the relative in public. More respondents would visit the relative's room—about two-thirds of adolescents and three-fourths of adults. Roughly 60 percent of adolescents and similar proportions of adults said they would shake his/her hand. There was obvious fear about closer contact—only 38 percent of adolescent males and 41 percent of adolescent females said they would use plates this individual had used. Similar results were found among

adults. There was even greater anxiety when it came to sharing clothes—less than one-third of both adolescent and adult groups said they would wear the relative's clothes. Likewise, many respondents were reluctant to let their children play with him/her—less than 40 percent of adult or adolescent respondents agreed that they would let their children play with the relative. There was, however, great empathy toward the infected person—nearly 70 percent or more of both adults and adolescents said they would take care of the relative if he/she were ill.

**Table 7.4 Percent Distribution of Respondents by Source of Information about HIV/AIDS, Kenya, 1994**

Source of Information	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=717)	Females (N=715)	Males (N=1,381)	Females (N=1,436)
Radio	68.1	56.3	80.2	61.4
Friends	33.4	38.3	39.8	43.0
School	22.7	22.2	4.8	3.5
Newspapers	21.7	14.4	32.6	10.3
Pamphlet, leaflet, and poster	15.4	11.6	19.8	9.5
Hospital/health care worker <sup>a</sup>	17.1	22.5	23.4	36.2
Television	10.0	8.8	12.3	6.1
Community meetings	8.5	7.8	14.5	15.6
Other relatives	7.1	11.7	6.6	11.7
CBD/outreach worker	2.0	1.2	2.6	2.7
Family planning provider	1.9	2.0	4.1	7.7
Nowhere	1.5	1.2	0.7	1.3

SOURCE:

NCPD and JHU/CCP Kenya National IEC

Situation Survey (1994).

NOTES: <sup>a</sup>Includes nurses, doctors, and other health workers except those specified on the list.

Multiple responses possible, percentages add up to more than 100.

**Table 7.5 Percent Distribution of Respondents' Reaction to a Relative if Infected with HIV/AIDS, Kenya, 1994**

Action	Adolescents 15 to 19				Adults 20 to 54			
	Definitely	Maybe	No	Don't Know	Definitely	Maybe	No	Don't Know
<b>Speak in public</b>								
Males	55.9	11.6	30.1	2.6	66.8	8.9	23.1	1.2
Females	62.4	7.0	29.2	1.4	67.4	9.4	21.4	1.8
<b>Visit his/her room</b>								
Males	64.0	16.1	17.3	2.7	76.8	12.0	10.3	0.9
Females	64.7	9.6	24.1	1.7	73.0	10.6	15.3	1.2
<b>Shake his/her hand</b>								
Males	59.8	13.9	24.3	2.1	67.2	13.6	18.4	1.0
Females	64.2	11.6	23.1	1.1	62.7	11.7	23.6	1.9
<b>Use plates he/she has used</b>								
Males	38.0	13.8	45.2	3.0	40.9	16.6	40.3	2.1
Females	41.3	13.4	44.1	1.2	40.0	12.3	44.8	2.8
<b>Wear his/her clothes</b>								
Males	28.3	14.7	53.8	3.2	29.0	16.1	53.4	1.5
Females	31.9	12.1	54.4	1.6	29.9	12.7	53.7	3.7
<b>Let children play with him/her</b>								
Males	29.8	15.2	46.0	9.0	38.5	16.9	41.4	3.2
Females	37.1	13.2	45.7	4.0	37.5	13.3	46.7	2.5
<b>Take care of him/her when he/she is ill</b>								
Males	68.8	14.5	14.1	2.6	76.4	12.4	10.2	1.0
Females	67.2	11.8	19.0	2.1	66.2	13.9	18.6	1.3

SOURCE:  
(1994).

NCPD and JHU/CCP Kenya National IEC Situation Survey

## Chapter VIII. Adolescent Reproductive Health

A major objective of this research was to obtain the public's opinion about a number of issues related to adolescent reproductive behavior. These included perceptions about female circumcision, sexual activity, marriage, and childbearing. Because of their sensitivity, most of these questions were largely confined to older adolescents and adults. When younger adolescents were included, their results are presented as well.

### Female Genital Mutilation

Researchers estimate that as many as half the girls and women in Kenya have undergone female genital mutilation (FGM). Procedures range from the milder Type 1 method to the most severe Type III method (infibulation) (Hosken 1993). FGM has become an important subject in the recent years, and the *Maendeleo Ya Wanawake* Organization, the largest women's group in Kenya, is spearheading activities to abolish the practice (Corso, 1996). President Moi declared female circumcision against the law as far back as 1982 (*Nairobi Times*, Sept. 6, 1982), but the practice continues.

In order to determine public opinion about female circumcision, respondents were read the statement, "The practice of female circumcision is alright and it should be continued." Possible answers were strongly agree, agree, disagree, strongly disagree, and don't know. Results show that over half the respondents are opposed to female circumcision. Most opposed are adult women ages 20 and above, where a full 67 percent are opposed to the practice (see Table 8.1).

**Table 8.1**  
**Percent Distribution of Respondents by Opinions about Female**  
**Circumcision, Kenya, 1994**

Opinion	Adolescents 15 to 19		Adult 20 to 54	
	Males (N=732)	Females (N=731)	Males (N=1395)	Females (N=1463)
Opposed	58.8	61.6	63.3	67.2
Supportive	23.8	29.0	30.3	26.2
Don't know/not sure	17.4	9.4	6.4	6.6

SOURCE:

Kenya National IEC Situation Survey (1994).

NCPD and JHU/CCP

## **Ideal Ages at Various Reproductive Landmarks**

Respondents were asked when they thought a girl should get married, when she should begin sexual relationships and when she should have children. The same questions were asked regarding boys. For girls, respondents thought childbearing should begin between ages 21 and 22, marriage between ages 20 and 22, but sexual intercourse should begin between ages 17 and 19—an average of three to four years before marriage. For boys, respondents thought childbearing should begin around age 26, marriage between ages 25 and 26, but sexual intercourse should begin between ages 19 and 21—nearly six years before marriage (see Table 8.2). Thus, for both young men and young women, the respondents placed sex chronologically before marriage. This implies a level of expectation or a degree of acceptance of premarital sex.

Respondents were asked in a separate question if they thought it was acceptable for a girl or boy to have sex before marriage. Less than a quarter of the respondents found it acceptable for a girl to engage in sex before marriage, and less than a third of the respondents found it acceptable for a boy to engage in sex before marriage (see Table 8.2). This suggests that respondents have conflicting views and some degree of ambivalence about premarital sexual activity for boys and girls. In fact, the reported ideal ages at first sexual experience are consistent with reality in Kenya. The 1993 KDHS shows that among women ages 25 to 49, the actual median age at first intercourse was 16.6 years, two years earlier than the actual median age for first marriage (NCPD, 1994). Therefore, respondents in the KNIECSS may be reporting as the ideal ages of sexual onset what they observe, even though they may be opposed to premarital sexual activity. This conflicting view of society may partly explain the hesitation to publicly support adolescent reproductive health programs in Kenya, leaving a fragile foundation on which to build such initiatives.

**Table 8.2**  
**Mean Age for Sex, Marriage, and Childbearing and Percent Distribution of**  
**Acceptability of Adolescent Premarital Sex, Kenya, 1994**

Opinion	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
<b>For girls:</b>				
Mean ideal age at first child <sup>a b</sup>	21.7	21.9	21.3	21.4
Mean ideal age at first marriage <sup>b</sup>	21.4	21.8	20.5	21.2
Mean ideal age at first sex <sup>a b</sup>	17.3	18.4	18.0	18.5
Percent that say it is OK for girls to have sex before marriage	23.3	18.4	21.3	14.4
<b>For boys:</b>				
Mean ideal age at first child <sup>a b</sup>	26.0	25.9	25.6	26.1
Mean ideal age at first marriage <sup>b</sup>	25.3	25.7	24.9	25.7
Mean ideal age at first sex <sup>a b</sup>	19.0	20.4	19.7	21.0
Percent that say it is OK for boys to have sex before marriage	30.0	23.9	31.5	21.8

SOURCE:

NCPD and JHU/CCP Kenya

National IEC Situation Survey (1994).

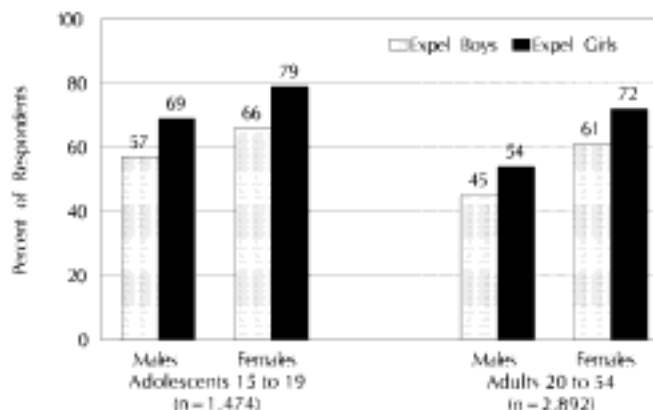
NOTES: <sup>a</sup>Among those who said "when married," age at marriage imputed for age at first event

<sup>b</sup>Excludes "can't say," "when ready," missing values, and others (values below 1st or above 99th percentile) that comprise 3 percent or less of the various samples.

## Pregnancy-Related Expulsion from School

The current practice in Kenya is to expel girls who become pregnant while in school, even though official government policy does not support such action. Studies show that anywhere from 8,000 to 11,000 girls are expelled annually because of pregnancy (Ferguson, 1988). Respondents were asked if they thought a girl who becomes pregnant or a boy who fathers a child while in school should be expelled. Results indicate mixed support for expulsion of boys, but stronger endorsement of the expulsion of girls. Roughly 45 percent to 66 percent of the respondents said the schoolboys should be expelled, but 54 percent to 72 percent felt schoolgirls should be expelled (see Figure 8.1). Females were more likely to support expulsion of either gender than were males.

**Figure 8.1.**  
**Respondents Who Think Pregnant Schoolgirls and Schoolboys**  
**Who Are Fathers Should Be Expelled, Kenya, 1994**



SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

## Views about Abortion

Abortion is illegal in Kenya, except to save the life of the mother. It is by no means uncommon, however. In the 100-bed acute gynecological ward at Kenyatta National Hospital, 90 percent of admissions between 1985 and 1987 were for incomplete abortion, and 40 women a day underwent dilatation and curettage as a result of induced abortions (Rogo, 1993). In most Kenyan hospitals, teenagers account for between 20 percent and 50 percent of all abortion cases (Lema and

Kabeberi-Macharia, 1992).

To assess feelings about abortion, respondents were asked whether it would be acceptable for a schoolgirl to have an abortion given several scenarios, such as her life being in danger, a deformed fetus, the pregnancy was the result of rape, and so on (see Table 8.3 for complete list of conditions). Results suggest general opposition to abortion. For example, only 43 percent to 58 percent would accept an abortion if the life of the mother was in danger. Less than half would approve if a schoolgirl had an abortion because the fetus was deformed. Fewer than one-third would approve even if she were raped, the fetus was a result of incest, or if the fetus presented a social challenge (e.g., the girl was still in school, the girl was unable to care for the child, or the baby's father refused responsibility).

On average, females were less tolerant of abortion than males. For example, while 55 percent of adolescent males would accept an abortion if the girl's life were in danger, only 43 percent of their female counterparts would. A similar trend was found among adults. In fact, less than half the females in both age groups, would tolerate abortion under any conditions presented.

**Table 8.3**  
**Percent of Respondents Who Would Approve of Abortion Under Certain**  
**Conditions, Kenya, 1994**

Condition	Adolescents 15 to 19		Adults 20 to 54	
	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)
Pregnancy endangered girl's life	54.8	43.1	58.0	45.3
Baby was deformed	42.5	30.6	44.1	29.8
Schoolgirl was victim of rape	31.4	32.8	29.5	21.7
Pregnancy was result of incest	31.0	27.9	26.9	23.5
Girl is still in school	23.5	21.6	17.9	15.9
Schoolgirl cannot care for child	23.7	21.1	19.3	16.1
Baby's father refuses responsibility	18.7	17.7	15.3	13.5

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

Respondents were also asked whether they knew anyone who had had an abortion. This question was confined to older adolescents because pretests revealed that many adults objected to being asked that. Roughly 38 percent of older adolescent males and 53 percent of their female counterparts said they knew someone who had had an abortion. About half the adolescent respondents knew one or two girls who had undergone the procedure, while the remainder knew more than two.

## Teaching Family Life Education

Respondents were asked whether young people should be taught family life education (FLE) by reading to them the following statement: "It is alright for young people to receive family life education or sex education in school." Respondent could agree or disagree with the statement, or answer "unsure" if they were uncertain. For this presentation, "don't know/unsure" responses were excluded from the analysis.<sup>9</sup> The overwhelming majority of respondents felt that young people should be taught

<sup>9</sup> Don't know/unsure comprised less than 10 percent of the respondents—6.5 percent of adolescent males, 7.3 percent of adolescent females, 3.0 percent of adult males, and 3.1 percent of adult females.

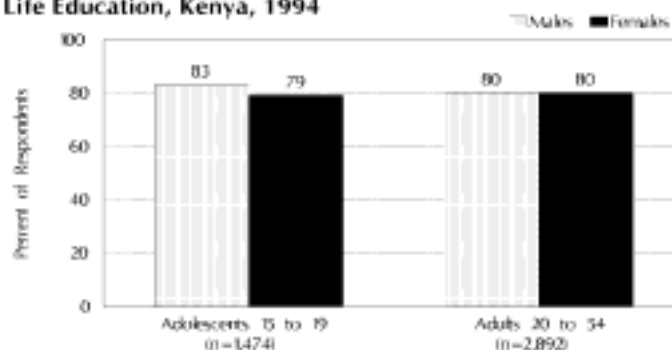


FLE. Only 20 percent or less of the respondents felt that young people should not be taught (see Figure 8.2).

To explore the acceptability of FLE further, respondents were asked whether young people should be taught a number of topics in school, ranging from puberty to alcohol and drug abuse. This time, younger adolescents and their parents were also asked the question. Results again suggest overall support for teaching these subjects. This was especially the case among older adolescents and adults. For example, upwards of 80 percent of older adolescents and adults felt young people should be taught about puberty, how a woman becomes pregnant, contraception, STDs and HIV/AIDS, and alcohol or drug use (see Table 8.4). Although responses among younger adolescents were not as high as these, nevertheless two-thirds or more agreed that young people should be taught these subjects.

Parents were equally supportive of teaching FLE. Over two-thirds of parents felt that young people should be taught each of the subjects listed on Table 8.4. Thus, the current opposition toward teaching FLE in Kenya frequently reported in newspapers appears to represent the views of a vocal minority. When asked whether boys and girls should be taught these subjects separately or together, respondents were almost evenly split between separating and combining the genders. In general, males were in favor of combining the genders, while females, especially the younger adolescents and their parents preferred the classes separated.

**Figure 8.2.**  
**Respondents Who Say Adolescents Should be Taught Family Life Education, Kenya, 1994**



SOURCE: NPCD and PHU/CCP Kenya National IEC Situation Survey (1994).

**Table 8.4**  
**Percent of Respondents Who Feel Adolescents Should be Taught Specific Subjects in School and How They Should be Taught, Kenya, 1994**

Subject	Adolescents 10 to 14		Adolescents 15 to 19		Adults 20 to 54		Parents of Youth Ages 10 - 14	
	Males (N=507)	Females (N=485)	Males (N=735)	Females (N=739)	Males (N=1,416)	Females (N=1,476)	Males (N=334)	Females (N=619)
Alcohol and drug abuse	77.8	70.2	92.4	92.1	92.1	92.2	83.6	83.2
Sexually transmitted diseases	74.5	69.8	91.8	92.7	91.9	92.6	78.1	83.4
HIV/AIDS	77.5	72.8	93.6	93.6	93.4	94.1	82.2	83.9
Birth control and family planning <sup>a</sup>	--	--	86.9	81.7	86.7	83.1	--	--
How a woman becomes pregnant	70.5	69.3	86.7	90.3	86.7	88.7	73.6	79.7
Wet dreams in boys	66.1	64.0	84.7	88.6	84.8	88.1	74.6	76.4
Monthly period in girls	65.6	72.0	88.9	94.5	88.7	93.7	72.3	81.6
At least one of the above	80.8	75.2	95.1	95.8	94.3	95.7	85.8	85.3
<b>Boys and girls be taught:<sup>b</sup></b>								
Together	58.0	37.5	57.4	44.3	51.3	40.2	51.6	32.9
Separately	39.7	60.1	40.0	52.1	41.9	54.8	40.3	63.6
Doesn't matter	2.3	2.4	2.6	3.6	6.8	5.0	8.1	3.5

SOURCE: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

NOTES: <sup>a</sup> Only asked of adolescents 15 to 19 and adults 20 to 54.

<sup>b</sup> Among those who said young people should be taught at least one of the subjects.

## Reproductive Maturity and Sexual Behavior

Older adolescents were asked if they had reached puberty (defined as experiencing menses for girls and wet dreams for boys) and if so, what they thought when they had their first experience. The objective of this question was to assess how prepared they were for puberty and how they may have coped with it. Roughly 73 percent of males said they had experienced wet dreams, and 86 percent of females said they had started menstruation (see Table 8.5). Just over half of those who had menses or wet dreams knew it was normal, and the remaining 40 percent to 50 percent had mistaken interpretations. Twenty-two percent of males and one-third of females thought they were sick, 4 percent to 8 percent thought they were hurt, and the remainder thought other something else had happened.

**Table 8.5**  
**Percent Distribution of Older Adolescents' Onset of Puberty and Their Reactions, Kenya, 1994**

<b>Experience and Thoughts</b>	<b>Males (N=735)</b>	<b>Females (N=739)</b>
Had wet dreams/Menstruation	73.2	85.5
Not had wet dreams/Menstruation	26.8	14.5
<b>Among those that had them, their reaction</b>		
Knew it was normal	62.8	57.0
Thought they were sick	22.1	30.7
Thought they were hurt	3.8	8.3
Other <sup>a</sup>	11.2	4.0

SOURCE:

NCPD and JHU/PCS

Kenya National IEC Situation Survey (1994).

NOTE: <sup>a</sup> Includes thought they were having sex, they were urinating in bed, etc.

Older adolescents were also asked if they had sexual intercourse. Findings are restricted to unmarried adolescents. Roughly 67 percent of unmarried males and 40 percent of unmarried females were sexually experienced (see Table 8.6).<sup>10</sup> The mean age at first sexual experience for sexually active males was 14 years compared with 15 years for females. The average age of the first partner for males was 14, the same age as the males' age at first intercourse. For females, the age of the first partner was 18.2, three years older than she was at her first experience. The current sexual partner for adolescent males was 16 years old compared with 21 years old for adolescent females. Thus, sexually active females ages 15 to 19 were involved with men, on average, who were four years older than they. Because partner ages were not verified, these results should be interpreted with caution.

Data were analyzed again for the most recent partner for females to further explore the prevalence of the "sugar-daddy" phenomenon—the practice of older men, often old enough to be their partner's father, seeking young women, mostly schoolgirls, for sex. Roughly 60 percent of sexually active females were dating men under 24 years of age. Of the remaining 40 percent, nearly 25 percent said their current partner was 25 years old or more, and 4 percent were at least 30 years old. Roughly 8 percent of girls did not know how old he was. The fact that 40 percent of these 15- to 19-year-olds were dating men ages 25 and older, however, raises the likelihood that some of these were "sugar-daddies."

When sexually active respondents were asked why they had intercourse the first time, most males (39 percent) said "to enjoy," while most females (38 percent) said to "show love" (see Table 8.6). An alarming 15 percent of females said they were "forced" to have sex the first time. The study did not investigate the meaning of "forced," but at the very least it indicates that the respondent was not a completely willing

<sup>10</sup> In the KNEICSS, 15 to 19 year-old females (regardless of marital status) were compared with their female age mates in the 1993 KDHS. The 1993 KDHS had found that 46 percent of these females had intercourse, and the KNEICSS found 47 percent had. This suggests that the two surveys are generally comparable.

participant in the event. Despite their limited sexual experience, results suggest the majority of sexually active adolescents have had more than one partner since their first sexual experience. Only 18 percent of males and 49 percent of females have remained monogamous. The mean number of sex partners for male is 3.7 versus 2.1 for females. Among males, 27 percent had more than seven partners, including some who said “many ” and “can’t count.” Nearly eight percent of females also had seven or more partners.

**Table 8.6**  
**Percent Distribution of Unmarried Adolescents Ages 15 to 19 Who Are Sexually Active and Mean Ages and Mean Number of Sexual Partners, Kenya, 1994**

<b>Sexual Behavior</b>	<b>Males (N=735)</b>	<b>Females (N=739)</b>
<b>Sexually active</b>	66.8	40.4
<b>Why had sex the first time</b>		
To enjoy self	39.2	17.3
To show love	27.8	38.0
To get the experience	22.9	19.9
Was forced	4.7	14.5
Don't know	4.0	8.9
Other reasons	1.3	1.4
<b>Number of partners so far</b>		
One	18.3	49.3
Two	15.9	21.9
Three	16.4	9.6
Four	7.3	6.0
Five	5.7	2.3
Six	4.5	2.2
Seven	5.2	0.4
More than seven, many, can't count	26.8	8.3
Mean age at first sex	14.1	15.0
Mean age of first partner <sup>a</sup>	13.8	18.2
Mean age of current partner <sup>a</sup>	16.4	21.3
Mean number of partners	3.7	2.1
Median number of partners	3.0	1.0

SOURCE:

NCPD and  
JHU/CCP Kenya  
National IEC  
Situation Survey  
(1994).

NOTE: <sup>a</sup>Excludes those who did not know their partners' ages, which was as follows: First partner, 5 percent for males and 7 percent for females. For current partner, 11 percent for males and 8 percent for females.

## Contraceptive Use among Sexually Active Adolescents

The KNIECSS also examined contraceptive use among the sexually active adolescent respondents. (Overall contraceptive use among adolescents is presented in Chapter V.) Of the 486 sexually active males, 40 percent had used a method of contraception at least once, 37 percent had used a modern method, and 13 percent had used a nonmodern method (see Table 8.7). Among the 343 sexually active females, 44 percent were never users, 30 percent had used a modern method, and 26 percent a nonmodern one. Roughly 26 percent of sexually active males and 28 percent of sexually active females were currently using contraception. The majority (20 percent of males and 16 percent of females) were using a modern method. Nearly 5 percent of males and 10 percent of females, however, were using a nonmodern method. The most common contraceptive among sexually active males was the condom (used by 21 percent), while the most common method among females was NFP (10 percent).

**Table 8.7**  
**Percent Distribution of Sexually Active Adolescents Ages 15 to 19 Who**  
**Have Ever Used a Contraceptive Method, Currently Using a Method,**  
**and Method Currently Using,<sup>a</sup>**  
**Kenya, 1994**

<b>Contraceptive Use</b>	<b>Males (N=486)</b>	<b>Females (N=343)</b>
<b>Ever Use</b>		
Any method	40.0	44.3
Modern method	36.9	29.5
Nonmodern method	13.0	25.7
<b>Current Use</b>		
Any Modern Method	22.4	15.9
Condoms	21.2	7.4
Pills	1.3	6.5
Injectables	0.4	2.2
Diaphragm	0.0	0.8
Foaming tablets	0.2	0.2
IUD	0.8	0.0
Norplant implants	0.0	0.0
Vasectomy	0.0	0.0
Tubal ligation	0.0	0.0
Any Nonmodern Method	4.6	9.6
Natural Family Planning <sup>b</sup>	3.6	9.6
Withdrawal	1.5	2.3
Periodic abstinence	0.9	0.2

SOURCE:

NCPD and

JHU/CCP Kenya National IEC Situation Survey (1994).

NOTES: <sup>a</sup>Use by respondent or partner.

<sup>b</sup>Includes counting days, safe period, and rhythm method.

## Knowledge of Safe Period

Because many young people were using the “safe period” NFP method as a method of contraception, respondents were asked to specify when the “safe period” (the period of maximal fertility during a woman's menstrual cycle) was. Acceptable answers were “any time she has sex” or “two weeks after her monthly period begins.” Results show that the majority of adolescents do not know when the “safe period” is. Among all respondents, less than one-fifth of males and less than one third of their female counterparts had the correct answer (see Table 8.8). Among the sexually active who were currently using the safe period as a method of contraception, only 19 percent of males and 35 percent of females actually knew the period of maximal fertility. The remaining 81 percent of males and 65 percent of females were incorrect, even though this is the method they were currently using. Thus, many young people depend on a method that they do not know how to use.

**Table 8.8**  
**Percent of Adolescents Ages 15 to 19 Who Know the Correct Definition of Safe**  
**Period, Kenya, 1994**

<b>Group</b>	<b>Males</b>	<b>Females</b>
All	16.9	28.0
Among sexually active	18.8	28.3
Among sexually active using safe period	18.8	35.2

SOURCE:

NCPD and JHU/CCP Kenya

National IEC Situation Survey (1994).





## Chapter IX. Conclusions, Implications, and Recommendations

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In this report we have presented the results of the Kenya National Information, Education, and Communication Situation Survey (KNIECSS). The survey, implemented in 1994, was conducted in 35 districts and covered 269 census clusters. It was designed to reflect the national population distribution and to mirror closely the 1993 Kenya Demographic and Health Survey (KDHS) sample. It was based on the same sampling frame used in the 1993 KDHS and comprised about half the clusters used in the 1993 KDHS. Where possible, questions in the survey were worded in the same way as in the KDHS, enabling direct comparisons. Review of the KNIECSS and the KDHS suggest that the two are fairly comparable. A total of 6,311 adults and adolescents were interviewed in the KNIECSS: 992 adolescents between the ages of 10 and 14, 953 parents of such adolescents, 1,474 adolescents between the ages of 15 and 19, and 2,892 adults ages 20 and above.

Approximately 50 percent of survey respondents were male, and just under 20 percent resided in urban areas. Virtually all adolescent respondents had attended school. Older respondents were less likely to have attended school, and in general, data suggest an increase in school attendance over recent generations. Data also show that males are more likely to be in higher educational institutions than females.

Anywhere from one-third to just under one-half of survey respondents belong to some type of social club, and women were more likely to belong to such a group than men. The most popular clubs were religious clubs and women's groups. Other popular clubs included sports clubs, music clubs, and self-help clubs.

### Mass Media Habits

**Newspaper habits.** When asked if they ever read newspapers, one-fifth of younger adolescents said they did. The fraction rose sharply among the older adolescent respondents and adults, with sharp differences by gender. Most people read the newspaper only one to three days a week, and only a few read daily. *The Nation* is the most widely read newspaper, with over 70 percent of newspaper readers reporting they read it. The second most popular newspaper was the *Standard* or *Taifa Leo*, depending on the age and gender of respondent.

#### ■ **Recommendations**

*Newspapers remain an important way to communicate with audiences, especially men. Campaigns using newspapers should use The Nation for maximum coverage. To reach those who are not literate in English, but can read Kiswahili, campaigns should use Taifa Leo.*

**Magazine habits.** Appreciable proportions of survey respondents of all ages reported "ever reading" a magazine. Most magazine readers read one magazine once a month. The favorite magazine among males ages 15 and above was *Weekly Review*; among females ages 15 and above, it was *Parents*. Among adolescent males ages 10 to 14, the favorite magazine was *Pied Crow*; for females it was *Parents*.

#### ■ **Recommendations**

*Programs that use magazines to reach males of reproductive age should use Weekly Review, while those reaching adolescent males ages 10 to 14 should use Pied Crow. Programs that use magazines to reach females of any age should use Parents, the most popular magazine for all females.*



**Radio habits.** The majority of respondents reside in households with a radio, with females being less likely to reside in such households.<sup>11</sup> Between one- and two-thirds of the sample listen to the radio daily. Adolescent girls ages 10 to 14 were the least likely to listen to radio daily, while adult males ages 20 and above were the most likely. The most popular listening times for listeners in all groups were from 6:00 p.m. onwards and between 6:00 a.m. and 8:00 a.m., bracketing the evening and morning news, respectively. Most respondents listen to the radio at home, but a sizable proportion, especially males, listen at a neighbor's or friend's house.

Over 75 percent of radio listeners prefer to listen to the Kiswahili station (KBC National Service). News is the most popular program across all age groups. Among adults, it is followed by health programs (e.g., *Afya Bora*, *Kuelewana ni Kuzungumza* and other family planning programs); among adolescents ages 15 to 19, it is followed by music, and among adolescents ages 10 to 14, it is followed by children's programs.

■ **Recommendations**

*Access to radio makes this medium the main way to reach large numbers of the population in Kenya. Listeners prefer to listen to the Kiswahili-language National Service station on KBC, and future interventions should consider using this language. Data also indicate that health programs, including family planning, are second only to the news in popularity, and these programs should be continued.*

**Television habits.** Less than 11 percent of all respondents, regardless of whether they own a television or not, watch television daily. Among those who watch television, over 90 percent watch KBC, and less than 25 percent watch KTN. The majority of those who watch television, regardless the station, watch between 7:00 p.m. and 9:00 p.m., with younger respondents watching programs on the earlier part of that time range. Unlike radio listenership, television viewership is a communal activity. Since the majority of households do not have a set, many people go to friends' and neighbors' houses to watch.

■ **Recommendations:**

*Data suggest that television may not be the best way to reach large numbers of the population due to limited access. It may, however, provide a way to reach people of higher educational status. Television may also be more likely to initiate dialogue about a topic, since many people watch it together. It should be noted that estimates of television viewership based on ownership alone can underestimate access to television, since many people who do not have a set visit friends and neighbors to watch.*

**Cinema habits.** Survey results suggest that cinemas are not an part of many people's everyday lives. For example, less than one-fourth of respondents had gone to a cinema the month preceding the survey. Moreover, those who went were most likely to have gone to the cinema only once during that time.

■ **Recommendations**

*While useful under certain circumstances, movies at cinema houses may not be the best vehicle to reach large audiences in Kenya. The study, however, did not assess access to mobile cinemas, which are popular in rural areas. The findings are therefore restricted to cinema houses.*

<sup>11</sup> This may be possible, given the larger proportion of single males, compared with single females. Many young males in Kenya pride themselves in owning electronic equipment, such as radios.

## Exposure to Family Planning Information in the Mass Media

**General exposure.** The majority of older adolescent and adult respondents had heard family planning information in the mass media in the six months preceding the survey. Radio, posters, and newspapers were the media sources most reported. Adult males were the most likely to report exposure to family planning messages, regardless of the medium.

**Exposure to *Kulewana ni Kuzungumza*.** The majority of adult men and women and a smaller majority of adolescents were exposed to the radio program, *Kulewana ni Kuzungumza*. Data suggest that the program is reaching men more than women. This breaks the long held perception that men are not interested in family planning, and presents an opportunity to address male-oriented issues in family planning, such as vasectomy and the role of males in family planning, in the program's format.

**Exposure to the Vasectomy Promotion Campaign.** Nearly one-third of adult men were exposed to the newspaper advertisements promoting vasectomies. They were the most likely to have been exposed to the campaign of all groups examined. Among men who read newspapers, just under one-half of adult males had been exposed to the campaign. These results show that newspapers are a potential medium for addressing male audiences.

**Exposure to *More Time*.** Exposure to the Zimbabwean film *More Time* was low. This was probably because *More Time* was shown for only a few months, and in Nairobi theaters exclusively. These results are consistent with the earlier finding that attending the cinema, especially pay cinema, is not an everyday activity for most respondents.

### ■ Recommendations

*The data contradict common perceptions that men are hard to reach, showing instead that most mass media programs reach more males than females. This suggests that male-oriented messages may be appropriate even when the messages are addressed mostly to women. For example, programs addressing women and family planning may increase their references to men. In addition, new initiatives to reach men may find a ready audience. Finally, new initiatives should build on the old ones. Programs such as Kulewana ni Kuzungumza should be continued, since over three-fourths of the respondents have been exposed to the program.*

## Knowledge, Attitudes, and Practice of Family Planning

**Awareness of the term “family planning” and source of information.** The concept of family planning has deeply penetrated Kenya. Less than 10 percent of respondents age 15 and above had not heard of the term “family planning” (or its vernacular translations). Men were slightly more likely than women to be aware of family planning. When asked where they had heard the term, most respondents in all subsamples, except adult women, cited radio. Adult women were most likely to cite health workers as their source of information. Data also suggest that schools are an important source of information on family planning for adolescents. In addition, many men cite public meetings and newspapers as their sources of information on family planning.

### ■ Recommendations

*Radio continues to be the prime source of family planning education for all subgroups examined, except adult women, where health workers are the main source. As discussed above, programming on radio should continue. Since many women are dependant on them, service providers should be appropriately trained and equipped to meet the needs of their clients. In addition, schools should be aware that they are an important source of information for youth, and provide youth with accurate and appropriate information. Finally, newspapers and public meetings are important venues to reach men.*

**Knowledge about pregnancy prevention and family planning methods.** While respondents are familiar with the concept of family planning, data show that detailed knowledge appears lacking. Data also show adolescents are less likely than adults to know the correct information about family planning, but appreciable proportions of adults also do not have the correct knowledge. This is especially disconcerting since adults are expected to advise adolescents. Knowledge levels of modern family planning methods were high among adolescents and adults. The most commonly cited modern methods were the pill and condom. Other popularly known modern methods (especially among adults) included injectables, tubal ligation, and IUD. Among nonmodern methods, Natural Family Planning (NFP) was the best known method. A significant deficiency in detailed knowledge, especially of how methods work still exists, however.

■ **Recommendations**

*To reduce contraceptive discontinuation and combat misinformation, the public needs more information about how specific methods function and how they are used. This is especially important for adolescents, who are less informed than adults. The public also needs information about other modern methods such as vasectomy and Norplant implants.*

**Attitudes toward family planning.** For the most part, respondents have favorable attitudes toward family planning and agree that family planning can benefit couples, mothers and their children, and the entire family. Fears about side effects of birth control linger—nearly one-fourth of men and one-third of women fear that family planning is not good for one's health.

■ **Recommendations**

*Family planning education programs should build on positive attitudes toward family planning to counteract fears about side effects. In addition, family planning providers should counsel users carefully about what to expect with contraceptive methods and to prepare the client for possible side effects.*

**Contraceptive use.** Data show that there were moderate levels of ever-use of family planning methods among respondents, with higher levels among adults than among adolescents. The majority of current users were using a modern method. Most common among adult women was the pill, and, among adolescent girls, the condom. Among adolescent and adult males, the condom is the most commonly used method.

**Source of family planning methods.** KNIECSS results show that adolescent males were most likely to obtain family planning methods from shops, kiosks, or similar outlets, while all other groups (adolescent females and adult males and females) were most likely to obtain their methods from a health facility. This pattern may be a reflection of the service delivery system in Kenya, a system known to be rather unfriendly to young people seeking contraception (Njau and Radney, 1995). Lack of access for young people and expense forces them to use unreliable methods.

■ **Recommendations**

*Because so many young people obtain contraceptives from commercial sources, and because most do not have steady income, price fluctuations can radically affect consistent contraception. Moreover, since commercial outlets do not provide routine counseling to contraceptive clients, many young people do not get this important service. Therefore, other sources of information such as schools, mass media and family become even more important. Schools should be encouraged to address adolescent contraceptive use in CBD programs, programs should be expanded, since they now only reach a fifth of women of reproductive age. These programs should also include adolescents and clients, for example by visiting schools and giving lectures to youth. They should also be trained to serve young clients since they provide the access and confidentiality young people need.*

**Reasons for not using family planning.** The main reasons for not using family planning cited by adult

married male and female nonusers is desired for additional children, recent births, and current breastfeeding. Among sexually active adolescent males and females, the main reasons given were that the respondent was “not married.” This suggests that adolescents, including sexually active ones, view contraception largely within the context of marriage. Many respondents said there was “no particular reason” for their not using family planning. Many of those not currently using family planning are likely to become tomorrow’s users—over half the current users, especially adolescents, say that they intend to use contraception “in the near future.”

#### ■ **Recommendations**

*Programs should inform young people about their potential need for contraception. Programs should explain to young people why they should use contraception when they are sexually active, not only in the future when they are married. For the many couples who do not use contraception because they want more children, educational interventions should address these individuals to encourage them and reduce their fertility targets.*

### **Contact with Health Care Providers**

**Community-based distribution (CBD) agents.** More adult respondents were aware of the existence of CBD agents than were adolescents. This suggests that CBD agents are more geared to adults than to young people, leaving a large number of potential clients unserved. CBD agents are in an excellent position to provide the sort of privacy young people may need. They can counsel young people about reproductive health matters and refer them to appropriate services.

Results also indicate that CBDs are referred to by many names, including family planning worker, health worker, or doctor. This means that in referring to CBDs in family planning communications, a simple word may not be sufficient, and that a description may be necessary.

Nearly 20 percent of adults (including those aware and those not aware of CBD agents) had been visited by a CBD agent in the preceding year. Among women of reproductive age (15 to 49 years), one-third had seen a CBD operating in their area, and one-fifth had received a visit from one.

#### ■ **Recommendations**

*CBD programs should be expanded, since they now only reach one fifth of the women of reproductive age. These programs should also include adolescents as clients, for example by visiting schools and giving lectures to youth. They should also be trained to serve young clients, since they provide the access and confidentiality that young people need.*

### **Interpersonal Communication**

**Communication between parents and children.** The survey found remarkable agreement between the parents and the adolescents regarding topics discussed, suggesting that parents and adolescents recall with reasonable accuracy the level of communication with each other. Data, however, also show that the majority of adolescents do not communicate with parents about reproductive health matters, such as boy-girl relationships or HIV/AIDS and other STDs. Even smaller proportions of parents had talked to their adolescent children ages 15 to 19 about sexual relations, puberty, abortion, or family planning. Parents mostly talked to their adolescent children about school, future careers, and alcohol and drugs. Data also reveal specific gender patterns in communication. Fathers were more likely to talk to their adolescent children about school, future career, and alcohol and drugs. Mothers were

more likely to have talked to the children about boy/girl relations, HIV/AIDS and other STDs, sexual relations, abortion, family planning, and puberty.

■ **Recommendations**

*While there is no doubt that parents should talk to their children, there are obstacles that must be removed before communication can flow. Programs should be developed to encourage greater parent-child communication about reproductive health issues. Parents need to know how to initiate discussions with their children, because children are increasingly more educated than their parents. Programs should encourage fathers to talk to their children about reproductive health, especially since they appear to be the most exposed to this type of information. Training initiatives to help parents share correct information would also be useful.*

Parents appear to discuss certain topics with only one gender. Adolescent males were by far more likely to have been told about alcohol and drug use, and future careers. Adolescent females, in contrast, were more likely to have been told about HIV/AIDS and other STDs, boy-girl relationships, sexual relationships, family planning, abortion, and puberty, perhaps because females are the ones who will get pregnant. This disproportionate focus on females removes a level of responsibility from the male, as well as places an unfair burden on the female. Data also show that adolescents prefer to discuss reproductive health matters with their friends, brothers, and sisters than with their parents. They also prefer to get information from health care providers and schools.

■ **Recommendations**

*Programs should help parents address both sexes equally and emphasize their equal responsibility. Programs should also help parents talk to **both** male and female adolescents about matters such as future careers and education in order to have successful men and women in the future. Peer programs, such as big brother/sister programs, should also be developed to provide adolescents with correct information and to encourage young people to talk with their brothers and sisters about sexual issues.*

**Communication about sexuality among adolescents.** When asked how comfortable they would feel talking about sexual matters to a number of individuals, adolescents appear most uncomfortable talking to parents, but more comfortable talking to health providers. Youth are also more comfortable talking to siblings and friends.

■ **Recommendations**

*Doctors, nurses, and other health care professionals appear to be acceptable channels of communication for youth. Programs can train these individuals in skills to communicate effectively with youth, and allow greater interaction between health care providers and youth. Health care workers can also be encouraged to explore reproductive health concerns with adolescent clients who may come for other reasons.*

**Communication between husband and wife.** Appreciable proportions of married men and women, especially adolescents, do not know how their partners feel about family planning. In addition, of the topics investigated (finances, future plans, children's education, religion, and family planning), married couples were least likely to have discussed family planning in the year preceding the survey. Among those respondents who had discussed family planning, wives said they were more likely to have initiated the discussion than their husbands. However, nearly half the men reported initiating the discussion. For the most part, the discussions were favorable toward family planning. A proportion of respondents, especially men, also showed desire or intention to speak to their spouse "in the near future."

### ■ **Recommendations**

*These trends suggest a level of apprehension toward family planning discussions perhaps because of beliefs that the discussion is unnecessary or that discussions may arouse suspicion or distrust. Programs to help couples discuss family planning, especially programs using role playing and teaching negotiation skills, may alleviate these concerns. Programs could use the mass media, such as plays and dramas, at facilities that serve women and men.*

**Communication with others about family planning.** When asked whom they had spoken to about family planning, adolescents ages 15 to 19 were most likely to say friends, school teachers, relatives, or spouses (if married). Few adolescents had talked with parents about family planning. Adults were most likely to have spoken to spouses, friends, relatives and health care workers. When asked whether they considered the opinions of various individuals as important to their (respondent's) use of family planning, adolescents considered the opinion of their teachers most important, while all the other groups considered the spouse to be the most important.

### ■ **Recommendations**

*Schools should recognize their critical role in educating young people about family planning, especially since most young people are uncomfortable talking to their parents. IEC programs could mold appropriate interactions between teachers and students. Parents should be trained and encouraged to communicate with their children.*

**Perceived support for family planning.** In general, individuals do not sense a great social support for the use of family planning. For example, while the majority (over two thirds) of the husbands in the adult subgroup believe that their wives would approve of their (the husband's) use of family planning, fewer than half the wives believe that their spouses would approve were they (the wives) to use contraception. Youth are even less likely to perceive such support. In addition, youth perceive only minimal support from other important figures: less than a third believe that school teachers, religious leaders, health care workers, and community leaders would approve were the adolescent to use contraception. Among adults, perceived approval is higher, but still only around half the respondents feel that these individuals approve of contraception. Many people did not know how key persons such as parents and friends would react to the use of contraception suggesting that these issues are not discussed adequately enough.

### ■ **Recommendations**

*Programs should encourage communication between spouses so that they are aware how the partners feel about contraception. They could model discussions among couples and include discussions with other key members of the social circle. Health care workers, religious leaders, teachers, and other influential figures who are supportive of family planning should be encouraged to speak out and to use forums such as community meetings or schools. Health care workers should be encouraged to support and discuss family planning with their clients who may come for other reasons. Advocacy efforts should be initiated to reach teachers, religious leaders, health care workers, and other influential figures who are not yet convinced of the benefits of family planning.*

## **HIV/AIDS Transmission**

**Knowledge and prevention.** Virtually all respondents ages 15 and above reported that they had heard of HIV/AIDS, but knowledge levels of HIV/AIDS remain low. Considerable proportions of both older adolescents and adults do not have correct information regarding HIV/AIDS transmission. Many also do not believe that condoms can protect against HIV/AIDS because of the fear they can burst or have holes in them. Compounding this problem, discussion about HIV/AIDS in the three months preceding the survey was low. Those who had discussed these issues were most likely to have talked to a friend, a spouse/partner, or relative.

**Reaction to a relative with HIV/AIDS.** Respondents' reactions to the idea of a relative with HIV/AIDS suggest that a high proportion would limit public and physical interactions with that person. Respondents

also reported that they would limit their children's play with the infected relative. The majority, however, said they would take care of the relative when he/she was ill.

**Source of information about HIV/AIDS.** The majority of adult and adolescent respondents get their information about HIV/AIDS from the radio. Males were more likely to cite this source than females. Other sources mentioned for all groups were friends, schools (adolescents), newspapers (adult men), and health care providers (adult women).

■ **Recommendations**

*Radio should be used to combat the many misconceptions and concerns people have about HIV/AIDS. Concerns about condom reliability should be addressed candidly in the mass media, by service providers, condom retailers, and others who can reach the various audiences. Programs should inform people of the truth about HIV/AIDS transmission.*

## **Adolescent Reproductive Health**

**Female Genital Mutilation.** The majority of respondents, especially adult females, are opposed to female circumcision and agree that the practice should not be continued.

■ **Recommendations**

*Advocates should use these data to support their efforts. These data should also be disseminated widely to work to reduce FGM, to consolidate public opinion against FGM, and to contribute to the legislative initiatives against FGM.*

**Ideal ages at reproductive landmarks.** Survey results indicate a social acceptance of premarital sex. The majority of older adolescent and adult respondents suggest younger ages for first sexual experience than for marriage for both males and females. However, when asked directly whether sex before marriage is acceptable, less than one-third said that it is. Such societal conflict presents a mixed message to adolescents. These diametrically opposing views may explain why adults are privately supportive of reproductive health education and services for young people, but do not publicly support them.

■ **Recommendations**

*These findings should be shared with parents, policy makers, program providers, and young people to help establish a unified message for young people.*

**Pregnancy-related expulsion from school.** The present operational policy in Kenya is to expel school-aged girls who become pregnant, while school-aged fathers often receive little punishment. Results suggest mixed support for the expulsion of boys but stronger endorsement for the expulsion of girls, with female respondents being more punitive than males toward pregnant school girls.

■ **Recommendations**

*Most respondents still opt to expel pregnant school girls, suggesting that this practice could continue if not aggressively prohibited. The Ministry's position on school girl expulsion should be disseminated and clarified to all concerned including teachers, parents and youth. A clear understanding of the consequences of expelling girls, and clear enforcement procedures, should be established so that appropriate actions can be taken.*

**Abortion.** Respondents remain opposed to abortion, with substantial proportions supporting abortion only in cases of endangerment to mother's life, fetal deformity, rape, or incest. Females were more opposed to abortion than males. At the same time, many older adolescent and adult respondents knew someone who had had an abortion, with some knowing two or more.

### ■ **Recommendations**

*Because most respondents are opposed to abortion, efforts must focus on nullifying the need for abortion by providing appropriate information and services to youth.*

**Family life education (FLE).** The majority of adolescents and adults felt that young people should be taught FLE in school. Adults felt STDs, HIV/AIDS, and alcohol and drug use education should be covered. Reproductive topics that adults felt should be included in the FLE were birth control, family planning, how a woman becomes pregnant, and puberty. These findings suggest that vocal opposition to FLE represents a small minority and does not speak for the majority of the population. Qualitative research among Kenyan policy makers show that they also support FLE (KYIP, 1995). Many leaders, however, also said that, while they endorsed FLE, they did not want this information shared in public.

### ■ **Recommendations**

*Wider dissemination of these results may give confidence to the public and show that FLE would receive overwhelming support if expressed publicly by parents and policy makers. Advocacy activities to empower the public to speak out would help address the problem. Also, ongoing efforts to reach policy makers should be strengthened.*

**Reproductive maturity.** Although the majority of older adolescent respondents reported onset of puberty based on experience of menstruation or wet dreams, roughly half did not know what was happening to them at the time. Many girls thought they were sick or had hurt themselves, while many boys thought they were sick or were wetting their beds.

### ■ **Recommendations**

*Youth should be adequately prepared for this important aspect of their lives. They should be told what is happening to them physiologically and why. Young girls should be advised explicitly about how to care for themselves during menses. Boys should be educated about wet dreams and why they occur to alleviate the many anxieties they are bound to have. Schools should be prepared to perform this task since many parents are ill-equipped for it. Ideally, the information should be given to youth before they reach puberty.*

**Sexual Behavior.** Sexual activity among older adolescent respondents was common, and the reported age at first intercourse was between 14 and 15 years old for both males and females. Multiple partners were also reported by sexually active adolescents, with males reporting more partners than females. The main reason males reported for having sex for the first time was “to enjoy myself,” while females said “to show love.” Nearly 15 percent of females said their first sexual encounter was “forced.” While the research did not investigate what “forced” meant, it implies that many girls did not willingly have sex for the first time.

At the time of the survey, a small proportion of sexually active adolescents said they were using a family planning method. The most common method used by males was the condom; among females, it was NFP. Sexually active respondents who are using “safe period” as a family planning method appear unaware of how this method works; when asked to specify the period of maximal fertility in a woman’s menstrual cycle, less than 40 percent of females and less than 20 percent of males knew the correct answer.

### ■ **Recommendations**

*The early ages at sexual onset and the pattern of having multiple sex partners, coupled with the misinformation about HIV/AIDS transmission, mistrust of condoms, and low levels of understanding of contraception suggest a highly vulnerable adolescent population and emphasize the need for education. Programs should provide young people the social and decision-making skills needed to deal with societal expectations about premarital sex. As long as most people are starting sex at an early age and before marriage, young people should be educated about methods, so they can have the correct information for choosing methods to prevent pregnancy and to protect themselves from HIV/AIDS transmission.*





## References

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- Corso, C. "Program For Appropriate Technology in Health-Efforts Towards Eradicating Female Genital Mutilation," Papers presented at the Johns Hopkins University School of Hygiene, February 20, 1996.
- Cross, A.R., Obungu, W., and Kizito, P. "Evidence of a Transition to Lower Fertility in Kenya," *International Family Planning Perspectives*, 17 (1991): 1991.
- Ferguson, A. *Schoolgirl pregnancy in Kenya*, Nairobi, Kenya, Ministry of Health, Division of Family Health, March 1988.
- Government of Kenya. *Development Plan 1989 - 1993*, Nairobi, Kenya, Government Printers, 1989.
- Government of Kenya. Economic Management for Renewed Growth. Sessional Paper No. 1 of 1986, Nairobi, Kenya, Government Printers, 1986.
- Grant, J. "Adult Fears, Remarks made at the Workshop on Youth." The Futures Group at the NGO Forum, International Conference on Population and Development, Cairo, Egypt, September 1994.
- Hosken, F. P. *The Hosken Report*. Lexington, Massachusetts, Women's International Network News, 1993.
- Kelly, A. C. and Nobble, C. E. "Kenya at the Demographic Turning Point? Hypotheses and Proposed Research Agenda," World Bank Discussion Paper No. 107, Washington, DC: World Bank 1990.
- Kenya Youth Initiative Project. "In-depth Interviews with Policy-Makers and Leaders," Nairobi, Kenya: Johns Hopkins University Population Communication Services, 1995.
- Kenya Youth Initiative Project. "Kenya Parents and Youth Speak, Are We Listening? Results of Focus Group Discussions," Nairobi, Kenya: Johns Hopkins University Population Communication Services, 1995.
- Kim, Y. M., Lettermaier, C. L., Odallo, D.O., Thuo, M., and Khasiani, S. "Client-Provider IEC Project in Kenya: Evaluation Report," Baltimore, Maryland: Johns Hopkins University, Center for Communication Programs, December 1996.
- Lema, V. M. and Kabeberi Macharia, J. *A Review of Abortion in Kenya*. Nairobi, Kenya, The Center for the Study of Adolescence, March 1992.
- Ministry of Health—Kenya (MOH). National AIDS Control Program, Preliminary Data, 1992, Nairobi, Kenya, MOH, 1992.
- Ministry of Health—Kenya (MOH) (National AIDS and STDs Control Program) and National Council for Population and Development (NCPD). *AIDS in Kenya: Background, Projections, Impact, and Interventions*, Nairobi, Kenya, MOH and NCPD, 1996.
- Morgan, W.T.W. "Kenya: Physical and Social Geography," in *Africa, South of the Sahara*. London, Europa Publications, 1993.
- Nairobi Times. "President Moi Bans Female Circumcision in Kenya." *The Nairobi Times*, Monday, September 6, 1982, Nairobi, Kenya.

National Council for Population and Development (NCPD). *Kenya Demographic and Health Survey 1993*, Nairobi, Kenya, 1994.

National Council for Population and Development (NCPD). *Kenya Demographic and Health Survey 1989*, Nairobi, Kenya, 1989.

Njau, W.P. and Radney, S. *Adolescence in Kenya: The Facts*. Nairobi, Kenya: Center for the Study of Adolescence, May 1995.

Population Reference Bureau. *1996 World Population Data Sheet*, Washington, D.C., 1996.

Population Reference Bureau. *1988 World Population Data Sheet*, Washington, D.C., 1988.

Republic of Kenya. *National Development Plan, 1989-1993*, Ministry of Planning and National Development, Nairobi, Kenya, 1993.

Rogo, K. "Manual Vacuum Aspiration Saves Lives," *Planned Parenthood Challenges*, 1993: 32-33.

United Nations. *1994 Demographic Yearbook*, New York: United Nations Publishing Division, 1996.

United Nations. *1988 Demographic Yearbook*, New York: United Nations Publishing Division, 1990.

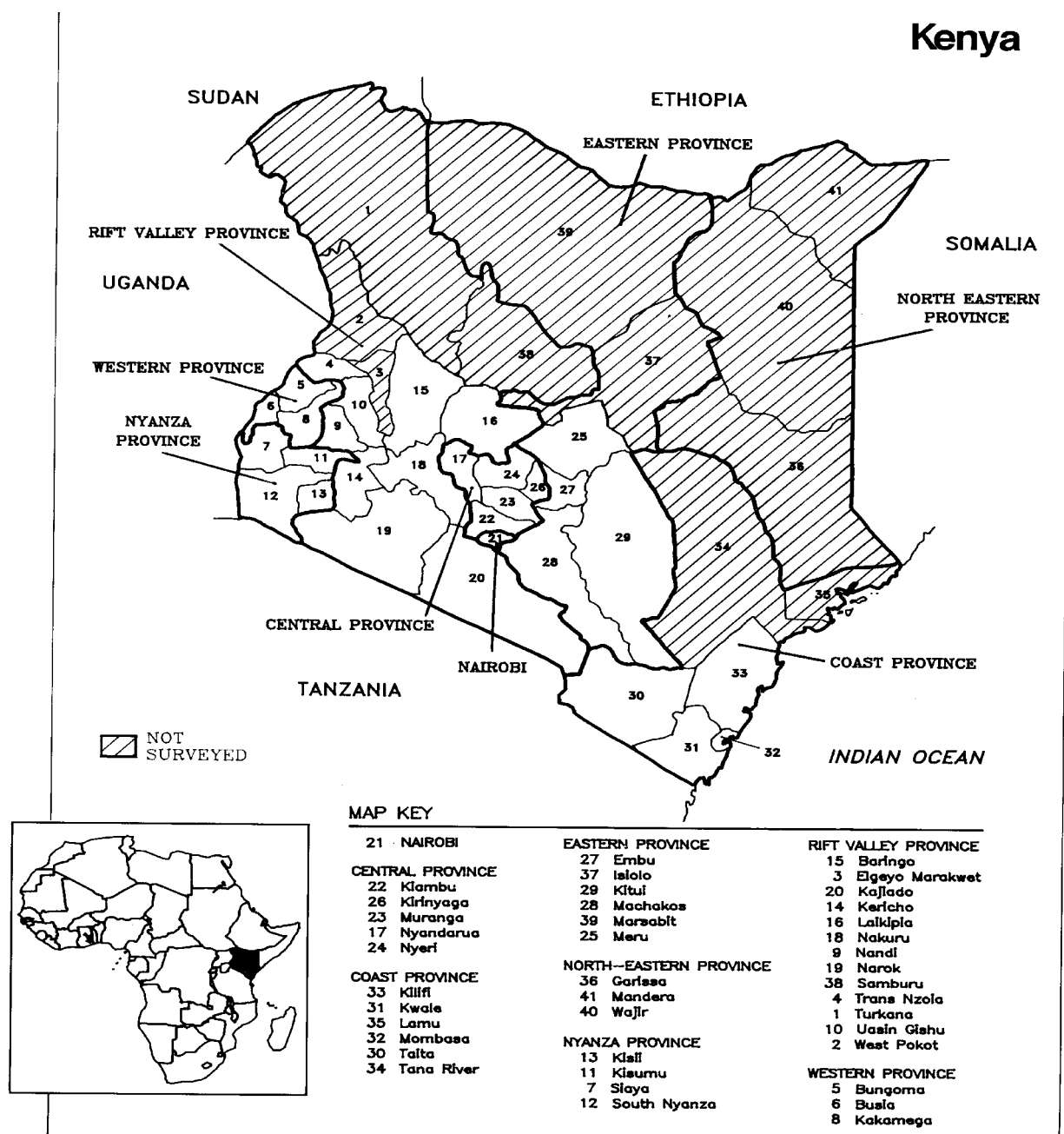
Westoff, C.F. and Rodriguez, G. "The Mass Media and Family Planning in Kenya." *International Family Planning Perspectives*, 21(1): 26-31, 1995.

World Bank. *World of Development Report, Development and the Environment, World Development Indicators*, New York: Oxford University Press, 1992.

World Health Organization. *World Health Report: Bridging the Gap*, Geneva: World Health Organization, 1995.

## Appendix A

### Administrative Map of Kenya



Note: Some districts had been recently subdivided into two or more districts. The former boundaries are shown here since they were used in this survey.

## **Appendix B**

### **Sample Design and Weights**

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The National IEC Situation Survey was conducted in 30 districts during August/September, 1994. The IEC sample was drawn from the National Sample Survey and Evaluation Programme (NASSEP III) - the current national master sample from of the Central Bureau of Statistics. The sampling design adopted for the master frame is a two-stage cluster design which is household-based and stratified into rural and urban areas. 1989 census enumeration areas (EAs) were selected with probability proportionate to size and formed the Primary Sampling Units (PSUs). The selected PSUs were segmented into clusters of an average of 100 households each, forming the Secondary Sampling Units (SSUs). The master sample consists of 1,048 rural and 329 urban clusters. The urban stratum comprises all centers with a population of 10,000+ including all district headquarters, regardless of population size.

A total of 269 clusters, 192 rural and 77 urban, with 8,455 sampled households were covered in the sample for the study. The following districts were not covered in the survey:

Tana River and Lamu in Coast Province  
Isiolo and Marsabit (Eastern Province)  
Garissa, Mandera and Wajir (North Eastern Province)  
E/Marakwet, Samburu, Turkana and West Pokot (Rift Valley Province)

Urban areas were over-sampled to provide an adequate sample to compare for the follow-up survey expected to be conducted later. However, results presented in this report are weighted to reflect the accurate urban/rural distribution in Kenya.

In order to meet the desired number of 26 completed interviews in each selected cluster, 30 and 35 households per cluster were sampled respectively for rural and urban areas. The selection of clusters as well as households within the sampled clusters was done by systematic sampling.

The details of the number of clusters in each district are presented in Tables A1 and A2.

#### **Sampling Probabilities**

The sampling probabilities were calculated separately for each sampling stage. Household weights by clusters were also calculated based on:

- i) NASSEP III cluster selection probability
- ii) IEC cluster selection probability
- iii) IEC household selection probability

**Table A1:**  
**Clusters and Households Used in the Survey**

District	Clusters Sampled		HHs Sampled		Total Sampled HHs
	Rural	Urban	Rural	Urban	
Kiambu	8	3	240	105	345
Kirinyaga	6	-	180	-	180
Murang'a	8	-	240	-	240
Nyandarua	6	-	180	-	180
Nyeri	8	-	240	-	240
Kilifi	6	-	180	-	180
Kwale	6	-	180	-	180
T/Taveta	6	-	180	-	180
Embu	6	-	180	-	180
Kitui	8	-	240	-	240
Machakos	8	-	240	-	240
Meru	8	-	240	-	240
Kisii	5	-	150	-	150
Nyamira	3	-	90	-	90
Kisumu	8	16	240	560	800
Siaya	8	-	240	-	240
S/Nyanza	8	-	240	-	240
Kajiado	6	-	180	-	180
Kericho	8	-	240	-	240
Laikipia	6	-	180	-	180
Nakuru	8	7	240	245	485
Nandi	8	-	240	-	240
Baringo	6	-	180	-	180
T/Nzoia	6	-	180	-	180
U/Gishu	6	3	180	105	285
Bungoma	8	-	240	-	240
Busia	6	-	180	-	180
Kakamega	8	-	240	-	240
Nairobi	-	24	-	840	840
Mombasa	-	24	-	840	840
<b>TOTAL</b>	<b>192</b>	<b>77</b>	<b>5,760</b>	<b>2,695</b>	<b>8,455</b>

Source: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

**Table A2:**  
**Numeric Designation of Clusters Used in the Survey**

District	Cluster Numbers							
Kiambu	0003	0006	0012	0016	0022	0026	0032	0035
Thika Town	1171	1174	1176					
Kirinyaga	0040	0044	0049	0052	0054	0059		
Murang'a	0062	0067	0071	0076	0080	0086	0092	0094
Nyandarua	0100	0104	0106	0109	0114	0119		
Nyeri	0121	0125	0131	0136	0140	0145	0151	0155
Kilifi	0157	0161	0165	0169	0174	0178		
Kwale	0181	0187	0191	0193	0196	0201		
T/Taveta	0218	0222	0226	0230	0234	0238		
Embu	0258	0263	0268	0270	0272	0277		
Kitui	0293	0297	0301	0305	0313	0317	0320	0325
Machakos	0330	0335	0339	0344	0348	0353	0357	0362
Meru	0382	0387	0393	0397	0402	0406	0412	0415
Kisii	0456	0464	0471	0476	0484			
Nyamira	0491	0499	0509					
Kisumu	0516	0521	0526	0531	0534	0536	0541	0547
Kisumu Town	1282	1283	1285	1286	1287	1288	1289	1290
	1291	1292	1293	1294	1296	1297	1298	1299
Siaya	0550	0555	0559	0564	0568	0573	0577	0582
S/Nyanza	0586	0591	0595	0600	0606	0610	0615	0619
Kajiado	0622	0624	0630	0633	0636	0642		
Kericho	0645	0649	0654	0658	0665	0669	0673	0678
Laikipia	0682	0685	0689	0694	0697	0702		
Nakuru	0706	0709	0712	0717	0723	0729	0735	0739
Nakuru Town	1319	1321	1324	1326	1328	1331	1332	
Nandi	0742	0747	0751	0756	0760	0765	0769	0775
Baringo	0802	0808	0812	0814	0820	0823		
T/Nzoia	0866	0871	0875	0877	0880	0885		
U/Gishu	0907	0911	0914	0915	0918	0922		
Eldoret Town	1350	1355	1358					
Bungoma	0954	0959	0965	0969	0974	0978	0984	0987
Busia	0992	0996	1000	1004	1008	1012		
Kakamega	1016	1020	1025	1029	1035	1038	1041	1046
Nairobi	1049	1055	1057	1065	1069	1073	1078	1082
	1091	1094	1098	1102	1107	1115	1120	1123
	1127	1137	1140	1144	1149	1152	1160	1164
Mombasa	1198	1200	1202	1205	1207	1210	1211	1212
	1214	1216	1220	1221	1223	1225	1227	1228
	1232	1234	1236	1237	1239	1241	1245	1246

Source: NCPD and JHU/CCP Kenya National IEC Situation Survey (1994).

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